

THE MEDICAL NEWS.

A WEEKLY JOURNAL OF MEDICAL SCIENCE.

VOL. LVI.

SATURDAY, MAY 3, 1890.

No. 18.

ORIGINAL LECTURES.

DERMOID CYST, COMPLICATED BY A TWISTED PEDICLE AND CONSEQUENT PERITONITIS. OÖPHORECTOMY DURING PREGNANCY FOR HYSTERO-EPILEPSY.

A Clinical Lecture.

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GENTLEMEN: I have a specimen to show you of considerable interest, a case of dermoid cyst, which I removed on the last day of November, 1889.

The history of the case is as follows: Mrs. R., puberty at fourteenth year, now fifty-seven years of age. She has carried this tumor for fifty-seven years, for dermoid cysts are born with the patients. She is the mother of two children, one thirty-three years of age, the other twenty-nine, both girls. The first child weighed nine pounds at birth, and the second six pounds. She remained in bed about ten days after each confinement, and nursed both children, which proves that there was no special disturbance during or after her confinements. She has had three attacks of pneumonia, the first attack having occurred before she was married, at which time she was ill five or six months. The second attack occurred in 1864, the patient being ill about a month; the third attack in 1880, when she was in bed ten days. During convalescence from the last attack, while sitting up, she suddenly expectorated three or four ounces of pus, which doubtless came from an abscess which had formed in the lungs as a result of the pneumonia. After this she rapidly recovered. Since these attacks of pneumonia she has had a continuous cough on rising from her bed in the morning and on lying down at night. Whether the cough had anything to do with the final development of this cyst, is a question.

Please notice that the last attack of pneumonia was in 1880. Eight years afterward, June, 1888, she had a slight attack of peritonitis, lasting about three days, and she suffered from soreness for some days after this attack. A second attack of peritonitis occurred in October, 1888. She was then confined to her bed for a week. The third and last attack of peritonitis, which was the most severe of the three, occurred in May, 1889, and was produced by stooping down. She went to bed that night and was obliged to remain there for a month, suffering greatly for some days, and, for a time, her life was despaired of. She was confined to her house two months. During these attacks of peritonitis the bowels were never as much constipated as is usual, and they were readily moved by laxatives.

The woman, I should have said in passing, was well developed, about five feet four inches in height, and weighed 180 pounds. After the last attack of peritonitis

she lost in weight. The tumor had been noticed for two or three years, and increased in size very rapidly during the attacks of peritonitis, apparently both from its own enlargement and the enlargement of the abdomen as a result of peritoneal effusion. The effusion gradually subsided, so that when the operation was performed the cyst did not seem to be as large as it had been a month or two before; in other words, the tumor seemed to be decreasing in size. It was found necessary to make an incision (in the median line, of course) ten inches in length. After opening the peritoneum there was very little fluid found in the cavity. The tumor was everywhere completely adherent to the peritoneum, but the adhesions were not strong, and were comparatively easily broken down with the fingers. The intestines and omentum, and everything that was adherent, were broken away from the cyst. So intimately associated were the peritoneal adhesions that at first it seemed almost impossible to remove them, but after it was found that they could be broken down with no difficulty the cyst was easily enucleated from its bed. It had the appearance of an ovarian tumor, white, but, because of the adhesions, not glistening. But on tapping it no fluid passed through the trocar. The trocar was removed, when this greasy or sebaceous material which I now show you began to exude. On making a large enough opening, about a gallon of the material welled out, but no fluid. In ordinary dermoid cysts there is usually a considerable amount of fluid, but in this case, if it had been present, it was taken up by the absorbent vessels after the last attack of peritonitis.

After the tumor was freed from all adhesions, and the sac drawn out of the abdomen, the cause of the three attacks of peritonitis was readily seen. The pedicle was only about the size of an ordinary lead-pencil, and seemed to consist of vessels with a little areolar tissue. The Fallopian tube upon the left side was found, but no ovary. The tube and ovary on the right side were atrophied as after the menopause. I confess that I did not search for the ovary on the left side with extreme carefulness, but I believe that the tumor represented all there was of the left ovary. The pedicle, as you see, was exceedingly small, and an interesting point is that it had been twisted through three complete revolutions. Remember that there were three separate attacks of peritonitis. During each attack there must have been a twist which did not completely obstruct the circulation, but which was sufficient to congest the tumor and set up peritoneal inflammation which, except in the last attack, was of short duration. The third twist seems to have obstructed the circulation to a greater extent. I am not sure that there was any circulation left. You will say, if there was no circulation through the tumor why did it not slough? My answer, and the only explanation I can offer, is, that the inflammatory adhesions had been so intimate through the thousands of minute

vessels connecting the wall of the cyst with all the surrounding viscera, that nourishment was kept up in that way. You know malignant tumors may gather new sources of vascular supply in this way, and fibroid tumors as they grow take on new life from the adhesions. In such cases the ovaries may be removed, but the tumor will not stop growing, receiving its nourishment from the adhesions which have been formed.

Now, I believe, though I cannot demonstrate it, that the last twist was sufficient to obstruct the circulation completely; and that the tumor did not die simply because it received nourishment from the adhesions. If the tumor had died the woman would have died also.

After the removal of the cyst the abdominal cavity was washed out with pure boiled water, and a glass drainage-tube inserted, and the patient made an uninterrupted recovery. Her highest temperature was 100.2°. Unfortunately she had a very troublesome cystitis on account of the frequent use of the catheter. The cystitis, however, passed away, after a short time, under antiseptic treatment.

I should have said that one of the attacks of peritonitis came on after stepping out of a carriage. Perhaps that was the exciting cause. In one other case it was certainly an exciting cause of the twist. When you have a tumor which seems somewhat movable in the abdomen with a sudden attack of peritonitis coming on after some exertion, as stooping, lifting, getting in or out of a carriage, especially if the patient be corpulent, you should suspect a twist of the pedicle, and if the patient's life is not endangered by the peritonitis, there may be no need of an operation in the midst of it. On the other hand, suppose the patient's life is endangered and you expect that she is not likely to live through the peritonitis, do not wait for her to die and make a post-mortem removal of the tumor, but operate in the midst of the attack of peritonitis, and in such cases the sooner you operate the better. Possibly the patient will recover from three attacks, but do not risk another. After the three attacks in this case there was no possibility of the tumor twisting any more, because it was so firmly adherent. This lesson was taught me some years ago by watching a patient in a hospital with an attack of peritonitis and a large abdominal tumor, upon whom we hoped to operate, but we wanted to get rid of the peritonitis before operating. She never rallied. We allowed her to die.

Post-mortem examination showed a sarcoma of the ovary about eight or ten inches in diameter, entirely movable in the abdomen, and with a twisted pedicle. I believe the tumor might have been removed and the patient's life saved if we had dared to operate.

HYSTERO-EPILEPSY—OÖPHORECTOMY DURING PREGNANCY.

The next patient I present to you has a history which has been most remarkable and is extremely interesting. She is apparently in perfect health to day. She first came to the clinic in October, 1888, and her history as given then was as follows: She was twelve years old at puberty, is now twenty-five, and was born in this country. She has been married six years; has had no children and probably no miscarriages. She has received treatment for five out of the six years of her married

life, wearing pessaries, and using tampons, wet and dry, all of which seemed to give her but little relief. She has been in the habit of losing consciousness for five to thirty minutes at a time, and is worse toward night. I might say, before reading her further history, that she is suffering from hystero-epilepsy. The epileptic seizures are more frequent and worse just before the menstrual period and last from five to thirty minutes. She does not froth at the mouth. She feels more comfortable after a sleep. Epileptic patients usually tell the same story. She feels better if left alone, and this is also true of most epileptic patients. The various attempts to bring them to consciousness by rubbing them, dashing water on their faces, pouring various remedies down their throats, is not agreeable to them; it makes them feel worse, they say, than if they were allowed to recover consciousness in their own way.

As a result of these epileptic seizures many patients begin to lose their memory after a time, and this was the case with the patient before you. Her bowels were constipated, appetite variable, she took cold easily, she had difficult breathing on exertion, and suffered from cold hands and feet, and she was exceedingly nervous. Menses were irregular before October, 1888. Sometimes three months would pass without menstruation; in one instance a year. She had a leucorrhœal discharge, usually white, but at times yellow in color, constantly for five years. She could not walk easily, and it gave her great pain to be on her feet.

Local examination found this state of affairs in the pelvis: The left ovary was resting upon the broad ligament, and adherent in that position, prolapsed and tender; the right ovary, also tender, was behind the uterus, where it was being irritated by the latter organ. Uterus sensitive. Pressure upon the uterus, and more particularly on the ovaries, made her feel as though she would have a convulsion, consequently the examination was not as thorough as it otherwise would have been. She had been married six years and had never been pregnant so far as she knew, and I supposed was not likely to be. She suffered from attacks of nausea at the time of the first appearance of the menses, and from shooting pains in both thighs, which were worse in stormy weather. This leads us to suppose that she was a victim of rheumatism also. Abdomen, hands, and feet were swollen; micturition was sometimes free, sometimes difficult, and attended with more or less pain. She had had spasms for two years before coming here. During these spasms her limbs were drawn up and she felt a sense of suffocation. They occurred either at night or early in the morning. This was in October, 1888. She had received a variety of treatment during five years without any apparent benefit, and as her memory was gradually failing and the ovaries were tender, adherent, and so much displaced, it seemed to me to be a case in which the removal of the ovaries was the only treatment that was likely to promise any satisfactory results. The operation was therefore done on November 20, 1888. The menses, you remember, had been irregular for some years, occurring, as stated, sometimes at intervals of six weeks, two months, and at other times even longer intervals, the last period having been September 28, 1888. She recovered from the operation satisfactorily and presented herself at the clinic after the opera-

tion very considerably improved. I saw her frequently during the winter of 1888-'89. She occasionally suffered from rheumatism. Of course she did not menstruate.

In the summer of 1889, while I was away, she began to feel very uncomfortable, with nausea and other symptoms. The abdomen gradually enlarged, and it soon became probable that she was pregnant, and as time went on there was no question whatever that she ~~was~~ pregnant. On July 31, 1889, she was delivered of a fine baby, which was presented in the clinic, and which she tells me is still alive and doing well.

The ovaries were removed November 20, 1888, and she has had no menstrual period since. I have the specimens of the ovaries and tubes in my possession, and I hope to be able to show them to you at some future time. I think I can prove to you that the ovaries were thoroughly removed, which is corroborated by the subsequent history of the patient. The patient must have been pregnant about a month at the time they were removed. I believe I should do the operation under the same circumstances if a case presented itself to-morrow, though perhaps I should be a little more careful in determining whether pregnancy was present at the time or not. The urgent necessity of doing something to prevent the menstrual returns, which were accompanied by the hystero-epileptic seizures, certainly must be acknowledged. I do not think any one will say that other treatment would have been better. If such a case presents itself to you, and the patient has been under skilful treatment for five or six years, as in this case, without any material benefit, it will become your duty to operate. This patient had received treatment of different kinds for five years, and we not unnaturally supposed that she would have been benefited by it in that length of time if it were possible. She would not, I believe, have gone through her pregnancy had the ovaries not been removed and the epileptic seizures stopped. She tells me to-day that since the operation she has had no return of the epileptic seizures. She has, however, about once a month, slight fainting spells, but which are not serious, and she is in far better health, as her appearance shows.

She suffers now from neuralgic or rheumatic pains in the ovarian region, and thinks there is still a tumor, but none can be found. This disturbance will continue for quite a time, but will gradually fade away as the organs atrophy. Undoubtedly there are permanent pathological conditions where the ovaries were, caused by the breaking up of the adhesions, and the cicatricial condition of the parts will give rise to neuralgic pains. Men who have had their limbs broken or dislocated suffer from rheumatic pains in the injured limbs. In other words, the cicatricial or abnormal tissues are the ones most likely to suffer.

While it is an interesting case and one upon which criticism might be made for removing the ovaries, yet when we consider the fact that she was under treatment for five years and was gradually growing worse, I feel that we were justified in removing the ovaries at that time.

I believe the ovaries and tubes were thoroughly removed or she would have menstruated again, and I am satisfied that there is no third ovary left from which she can subsequently become pregnant, or from which she

is likely to have trouble. Her future will be a decided gain upon her past. She has been relieved of the hystero-epileptic seizures, but she will be nervous, perhaps for years, because she has a weak and shattered nervous system from which it will take a long time to recover.

The right ovary was five or six times its normal size; the walls of the right tube were thickened, and its fimbriated extremity was closed and had developed into a cyst the size of the diseased ovary and was filled with a serous fluid. The right ovary and diseased tube lay behind the uterus and were constantly teased by the pressure of that organ. The left ovary and tube rested upon and were adherent to the broad ligament. This ovary was two or three times the normal size, and the tube was shortened and thickened and partially adherent to the ovary at its fimbriated extremity.

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NEPHRECTOMY. SARCOMA OF THE JAW. TUBERCULAR ABSCESS. ALVEOLAR SARCOMA.

*A Clinical Lecture
delivered at the Hospital of the Jefferson Medical College,
February 8, 1890.*

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NEPHRECTOMY.

GENTLEMEN: I shall, in the first place, occupy a few minutes in showing you a specimen which I removed yesterday. The patient is a young woman, aged twenty-four years, who had undoubtedly for some years a floating kidney. As a result there developed first an intermittent and later a permanent hydronephrosis. This formed a large cystic tumor in the abdomen which was tapped and drained by my friend Dr. Joseph Price. The operation was followed by a urinary fistula. Dr. Price informs me he would have removed the kidney had the condition of the patient warranted it. My attention was recently called to the case by Dr. James C. Wilson, her attending physician. I found a considerable quantity of pus as well as urine discharging through the fistula. In addition there were only from nine to twelve ounces of urine secreted by the healthy kidney (the left), and I decided not to operate until this kidney should be whipped into greater activity. In order to determine whether the ureter of the right kidney was patulous and therefore whether the urine from the bladder all came from the left kidney, I injected milk through the fistula on the right side of the abdomen and a little later drew the urine. I found the urine free from milk and concluded that the right ureter was impervious. As ascertained by Dr. Charles M. Wilson, the urine of the left kidney was free from albumin and sugar, though its percentage of urea was normal, while the discharge from the fistula contained albumin and pus and its percentage of urea was much diminished.

Under suitable treatment the left kidney became more active and her condition improved so much that I operated yesterday. The difficulty, as you can readily understand, was to secure an aseptic operation, in view of the constant discharge of urine and pus from the fistula. Dr. Charles M. Wilson first closed the fistula by his finger. Then the abdominal wall was quickly

cleansed by a 1:500 sublimate solution. Next, I made a vertical incision into the peritoneal cavity very close to the fistulous opening, and as quickly as possible got my thumb and finger in so as to seize the neck of the sac that I might prevent any contamination of the peritoneal cavity by the urine and pus. I then made a short transverse incision and dissected loose the mouth of the sac. As soon as this was ascertained to be free from any adherent intestine it was clamped by a large pair of forceps. Then I readily drew out and removed the kidney and sac which I now show you. The temperature this morning is 99.8° and she has secreted eleven ounces of urine in less than twenty-four hours. Her prospect of recovery is therefore good.

[NOTE.—In one week the stitches were all out. She made an excellent recovery, the other kidney secreting from thirty to forty ounces of urine a day.]

RESULT OF OPERATION FOR TUMOR OF THE BREAST.

I have next to show you the case of amputation of the breast for cancer on which I operated one week ago. I have seen this wound twice. The first time was twenty-four hours after the operation. You will remember that the breast was amputated, but as the tumor was pretty clearly a fibroma and as the axillary glands were not involved, I did not open the axilla. But I did not hesitate to remove the entire breast and tumor, for at her age, forty-two years, I am fearful that any tumor of the breast may undergo malignant degeneration. On Sunday morning I removed the dressing, which was saturated with blood, and took out the rubber drainage-tube. The dressing was again removed on Wednesday and there was scarcely a stain upon it. At that time I removed one-half of the stitches and the horse-hair drain which had been left to favor the escape of the slight serous oozing. The wound is now, as you see, practically healed in one week, and the patient will probably leave the hospital to-day. The temperature has not been over 99° and most of the time it has been normal.

This is the result that I always expect, and if I do not obtain it, I am sure that there has been, on my part, some mistake, either of omission or commission.

SARCOMA OF THE CHEEK AND JAW.

The next case which I bring before you is one which I approach with a great deal of hesitation. The growth involves the whole of the left side of the lower jaw, the cheek, and a large portion of the floor of the mouth. It is growing rapidly, and although it began only some ten weeks ago, has reached a large size. The question in my mind was whether or not any operation should be done. I have put the matter frankly before the patient and he decides in favor of operation. Professor Brinton and Dr. Hearn saw the case with me a few days ago, when all the possibilities were laid before the man and he decided to accept operation. If it were not for his positive decision, I should prefer not to operate.

The dangers of the operation are twofold. The first is hæmorrhage. The tumor goes rather deeply under the jaw and almost certainly involves all of the branches of the carotid artery with the exception of the posterior ones, and we shall, therefore, have abundant hæmorrhage. The jugular vein as well as the carotid artery is probably involved in the growth. And this causes two

unfavorable complications. As the operation involves the mouth, the blood will pass into the trachea, obstruct the breathing and so interfere with the operation, and it will also favor the development of pneumonia. In order to avoid this danger, I propose to perform a preliminary tracheotomy and then use the canula of Trendelenburg. This, as you see, is a tracheal tube having around it a little bag of rubber which can be distended by compressing the bulb connected with it. When inflated the rubber bag completely fills the trachea so that no fluid can enter from above. By means of a flexible tube connected with the tracheotomy tube proper the chloroform enters the lungs. The use of such apparatus is a necessity in certain operations about the mouth where much bleeding is inevitable. Some of you saw Professor Annandale, of Edinburgh, operate in this amphitheatre eighteen months ago, using this apparatus in a case of naso-pharyngeal polyp.

Another and greater danger is that the hæmorrhage may prove directly fatal. In a large professional experience it has been my good fortune so far never to lose a patient on the table. The nearest I have come to it was in a case of lumbar nephrectomy for cancer where it was impossible to complete the operation on account of adhesions. The hæmorrhage was abundant and the patient died three hours after the operation. It is not impossible that this patient may die upon the table. Even if the hæmorrhage is not quickly fatal it will be a severe shock to him and be a source of great danger at a later period.

As it will probably be necessary to tie all the branches of the carotid artery—the thyroid, the lingual, the facial, the temporal, the internal maxillary and smaller muscular branches—I propose, in order to avoid the primary hæmorrhage, which not only impedes the operation but also causes immense shock to the patient, to ligate the carotid artery prior to the operation upon the tumor itself.

I have told the man definitely that the chances are that the tumor cannot be removed, that he has a fair chance of dying from the immediate operation as a result of shock and loss of blood, that there is a chance of his dying later from septic trouble, for it is impossible where we have to remove the jaw, a part of the cheek and a part of the mouth, to have an aseptic wound. It cannot be kept so on account of the exposure to the air, the saliva and the food. I have also told the man that after I have removed this as well as I can, it will probably recur and destroy his life. All these possibilities, I have frankly laid before him and still he elects operation. Is it my duty absolutely to decline to operate? This is a grave question, one of those questions which affect a man's moral as well as his professional sense. The conclusion which I reached long ago after a careful consideration of this question is, that if after all the dangers of an operation are faithfully and honestly laid before the patient he elects operation, the surgeon should be willing to give him the one small chance that he has, provided there is a reasonable possibility of his recovery. Suppose even that this case is fatal in an hour, or twenty-four or forty-eight hours, how will that compare with doing nothing? He will have a painless or practically almost painless exit. It will be speedy, and I confess that, so far as I am concerned, had

I such a growth, I should pray for the speediest death that could come to me. I do not expect to do much toward prolonging this patient's life; I may even terminate it more quickly than it would otherwise would be, but I am giving him, at his own positive choice, the only possible chance that he has. I may be unable to complete the operation, but I shall take away all that I can.

While the patient is being brought in I will give you briefly his history.

George B., aged thirty-six years, born in Philadelphia, was admitted to the hospital February 3, 1890. His occupation is that of a boiler-maker. He states that one year ago he had the roots of two decayed teeth extracted leaving a sound one between them. This was on the same side of the jaw (the left) that the growth now occupies. He also noticed a small kernel the size of a Lima bean just beneath the body of the left inferior maxilla, but paid no particular attention to it. Three months ago he was struck with considerable violence just above this kernel by a flying rivet-head. The bruised spot became slightly swollen and red. Two weeks after the injury he consulted a physician and tincture of iodine was applied for a fortnight without improvement. Then the sound tooth above mentioned was extracted with the hope that this would permit the escape of pus. The cheek, however, continued to swell and the gum also became enlarged. Poultices were then applied, and two months after the bruise the swelling was lanced and a small amount of pus and blood discharged. The tumor then somewhat diminished in size, but still remained hard. When admitted five days ago there was a discharge of bloody serum, and when pressed upon pus and blood-clots escaped. The tumor has doubled in size in the past four weeks.

Now that the patient is before us, you see the tumor, which is as large as a fist. I employ chloroform as the anæsthetic in this case, because if we use the Paquelin cautery there will be no danger of fire as would be the case if ether were used.

The man, you will observe, takes chloroform very badly; his pulse is feeble and his color bad, and in face of these new conditions the question again arises whether I should proceed with the operation, which, as I have explained to you, is of a threefold character: tracheotomy, ligation of the carotid, and removal of the growth. I will ask Professor Brinton to examine his condition.

After consultation with Dr. Brinton I am decidedly of the opinion that I should do nothing. I might tie the carotid, which would probably diminish for a time, at least, the rapid growth of the tumor, but his condition is such that I think it unwise to undertake even this part of the operation. Death would be inevitable in a very few minutes.

You can now easily understand, gentlemen, how the judgment of the surgeon must instantly vary with changing conditions, and this case is much more profitable to you as a lesson than if you had seen the operation. I should be very foolish—not only foolish, but I should do wrong if I attempted to do an operation which would absolutely give no chance, but kill the patient on the spot. We never have a right to do that. While I might pray for a speedy death if I had such a disease myself, yet I have no moral right to give this man an euthanasia

either by chloroform or by operation. This question arose a few years ago and was widely discussed in the medical and popular magazines for a long time. The almost universal conclusion, in fact so near universal as to make the exceptions prove the rule, was that we have no right in a case of cancer or other at present incurable diseases to set the limits and say "thus far shalt thou live and no farther," and to give one what has been properly called an euthanasia, a happy, easy death. We have no right to destroy life, though we may risk life. We may run great risks to save or to lengthen life, just as a general will run great risks for victory, but we are not justified in going into absolute and certain defeat.

TUBERCULAR ABSCESS.

The next patient that I bring before you is a colored woman, twenty-three years of age. Six months ago, after lifting a heavy weight, she felt pain just above the right breast. The pain continued for one month. She then consulted a physician and topical applications of iodine were advised. Later a hard lump appeared, the pain leaving on its appearance. The lump has gradually increased in size and is now half as large as the fist.

The family history is that the parents and grandparents are healthy, but a sister of the patient died one year ago at the age of twenty-one, of phthisis. This is the only case of consumption in the family so far as we have been able to ascertain.

You see here a soft, fluctuating tumor over the manubrium and under the inner end of the right clavicle. It is painless and is growing slowly. The skin is perfectly natural and there is no sign of an acute abscess. But the tumor evidently contains fluid. My judgment is that it is a so-called "cold abscess," which is really no abscess at all, for the matter present is not pus. It has been proven beyond cavil that such matter is the result of tubercular degeneration and not a purulent product. There is no fever in this case. If this were a phlegmonous abscess it would have ruptured long ago.

The question comes up, What shall we do for it? What I like best is the introduction of ether and iodoform. Originally glycerin and iodoform were employed. The advantage of ether is that it vaporizes the moment it enters the sac and carries the iodoform into every crevice. The *modus operandi* is very simple. I shall employ this aspirator, which is provided with a two-way stop-cock. It can, therefore, be used either to remove or inject fluids. I employ the largest sized canula that goes with the instrument. The stop-cock being shut off the piston is withdrawn, making a vacuum in the barrel of the syringe. The needle is then introduced through the skin and when the eye has disappeared the stop-cock is turned so that the vacuum is continuous to the end of the needle. The needle is then forced onward, and as soon as fluid is reached it will be seen as it passes through the little glass tube inserted in the rubber tube which connects the needle to the syringe. When the syringe is full the stop-cock is turned so that the fluid can be thrown out into a basin. Another syringeful is withdrawn in the same way and this process is continued until the sac is emptied. All the broken-down matter being removed the cavity is washed out with warm boiled water. Having washed out the sac, I am

ready to introduce the ether and iodoform. The strength of this is one to twenty, and the quantity injected should not contain over one drachm or a drachm and a half of iodoform.

There are two things to be considered in connection with this patient. One is: Are the sternum and the ribs involved? I think it probable that this "cold abscess" has arisen from some disease of these bones, the result of her violent effort. It may possibly prove necessary at a later date to lay open the swelling and remove the carious bones. The second point, which is of considerable importance, is: Does this cyst communicate with the cavity of the chest? How can we tell? By continued compression. I have tried this, and there is no evidence that there is any communication with the chest. If there were, I should hesitate to inject a large quantity of this solution.

The diagnosis here is tubercular abscess, and I see no reason to doubt its correctness; but we must remember one thing, and that is that we all make mistakes. I am more charitable than I used to be, for I have made a good many mistakes in my day. You remember in the case we had a week ago to-day how the diagnosis wavered—first a cyst, the character of which was uncertain, then it was thought possibly to be a growth connected with the submaxillary gland, and finally, after dissecting out the submaxillary we reached a sebaceous cyst near the floor of the mouth, undoubtedly resulting from invagination of the skin in foetal life. There is always a possibility of mistake in these cases. I bring them before you, and if I am wrong you will see it. I shall never forget a mistake that I saw made by the distinguished Langenbeck, of Berlin, a most skilful operator and accurate diagnostician. While I was at his clinic in the winter of 1865 and 1866, he diagnosed a tumor as a mammary scirrhus and at once removed the breast. After taking it out he turned to the class and cut it in half, and was a good deal surprised when he opened an abscess of the breast. Looking at it for a moment, he naively remarked: "Well, gentlemen, I never made that mistake but once before." Those of us from America remarked that that was a new way of opening an abscess of the breast—first to remove the breast and then open the abscess.

Before I inject the ether and iodoform, I shall take advantage of the flaccid condition of the sac to explore the condition of the bones beneath it. I find a deep cavity over the sternum, so that this is probably a cold abscess arising from traction by the pectoral muscle on the sternum and possibly also the ribs. I now introduce the ether and iodoform, proceeding slowly so as to determine the effect of the vaporization of the ether. This is at first a little painful, but the solution soon exerts its anæsthetic effect. As you see, the sac at once becomes distended and is larger than before it was emptied. One trouble resulting from this is that the pressure is so great that when the finger is removed from the opening a quantity of the fluid is apt to be forced out. In order to avoid this as much as possible, I apply a large piece of rubber plaster over the opening and secure it by a bandage.

A lumbar or psoas abscess can be subjected to this treatment, and sometimes in twenty-four hours the patient can go about, although I prefer to keep him quiet for at least two or three days. Two or three injections may sometimes effect a cure. Occasionally even one is

sufficient—as in a little girl of fourteen years, now in the wards, cured of such a tubercular "abscess" a short time since by a single injection.

RARE FORM OF ALVEOLAR SARCOMA, SURROUNDED BY A LAYER OF VARICOSE VEINS.

The case that I shall now show you is, I think, an example of a very common form of tumor, but as I have told you before, there is nothing so uncertain as the character of a tumor. You can say that it is a soft or a hard tumor, but to say positively what is its nature is very difficult. Your patients, however, expect you to know all about it, and you will be constantly asked whether a certain growth is a "cancer" or a "tumor." In other words, whether it is malignant or benign. You are generally pretty safe in pronouncing it a "tumor," and in your opinion to the patient you need not go any further. You may say to yourself that it is a fatty or a sebaceous or other form of tumor, but do not be too sure in telling the patient, for you may find that it is not the kind of tumor that you first thought.

This tumor has been present for three years. It occupies the posterior part of the left thigh. It is not painful. It is movable. While it does not fluctuate, it is just on the verge of it. It is soft and resilient. You must remember that at the temperature of the body the fatty and sebaceous matter that we have in the tissues is not solid, as you see the fat about a sheep's kidneys in the shambles, but almost fluid. This tumor has no pulsation. Taking these facts into consideration, my decided conviction is that this is a fatty tumor. As I have told you on another occasion, there are two kinds of fatty tumors. One is a pure fatty tumor which is lobulated. Such a tumor can be enucleated without difficulty. There is a second form, a fibro-fatty tumor, in which there is a considerable amount of fibrous tissue. These fibrous trabeculae stretch out in all directions and are attached to the skin, making it much more difficult to remove, as they have to be cut through.

Is it possible to tell which variety of fatty tumor you have? Generally you can. If you grasp the skin over the tumor and pinch it up, if the tumor is of the fibrous variety, each little fibre will draw down the skin and produce pitting. This would be absent in a pure fatty tumor. The proper thing to do with a fatty tumor is to take it out. I have never seen such a growth undergo malignant change. They, however, never get any better. They frequently become so large as mechanically to cause great inconvenience and annoyance. I have seen the skin over them ulcerate and the greatest discomfort produced.

While the patient is being etherized, let me say a few words in regard to the organization of an operation. Before you begin any operation you must decide what instruments, what special appliances, and what dressings will be needed. Give a written list of them to the nurse the day before the operation, so that everything shall be ready before operating. Many years ago I had a printed formula made out showing what preparations should be made in the room, the bed, the patient's person, and what instruments, dressings, etc., would be needed. I have found this a most useful plan, saving me a deal of time and annoyance. You must not forget the dry bichloride of mercury towels. I have seen more than one patient suffer decidedly from cold, shock, and rheuma-

tism in consequence of the wet antiseptic towels spread over the field of operation. I never use the wet towels except in an emergency. In ordinary cases, I direct that the night before operation one or two dozen towels be wrung out of a 1 : 1000 bichloride solution, hung up and dried. They are then folded and an antiseptic towel wrapped around them. These are spread around the site of operation. In the hospital sheets are prepared in the same way. In operations about the head and neck, where the patient is liable to throw his hands about, it is well to pin a prepared towel around his arm. The operator can then grasp the arm without danger.

We shall now proceed with the operation. The tumor, as you see, occupies the posterior part of the left thigh. You observe that there are numerous varicose veins in this region and we must avoid them. I make an incision in the axis of the limb and immediately come down on the tumor, which now does not present the appearance of a fatty tumor. When I saw these varicose veins, the idea of a blood tumor suggested itself, but the fluctuation did not seem distinct enough for that. Making a small incision into the tumor, there is at once a free discharge of venous blood. I close the opening with hæmostatic forceps. It will be necessary to enucleate this mass very carefully, for these varicose veins always have very thin walls. Underneath these veins is a more resistant mass, much harder than the veins, but yet approaching to fluctuation. You see now how deceptive a tumor may be. All the physical signs here were those of a very common form of tumor—a lipoma. Dissection reveals a very rare form of tumor, for Professor Brinton tells me that he recalls only one instance at all like this, and I cannot myself remember ever to have seen even one similar case.

[NOTE.—The operation was prolonged by the numerous fibrous trabeculæ, which had to be cut one by one with care so as not to injure the large varicose veins on the surface. Eventually the entire mass was dissected out and removed, no pedicle, vascular or otherwise, being found. When removed a large opening in the fascia lata was found immediately under it. Dr. Coplin examined it and found it a soft alveolar sarcoma covered with a layer of varicose veins. It had probably originated in the connective tissue under the fascia, later forced its way through this dense fascia, the fibres of which produced the trabeculæ above described. The patient was shown to the class a week later entirely well, his highest temperature having been below 100° F.]

ORIGINAL ARTICLES.

THE TREATMENT OF MEMBRANOUS DYSMENORRHOEA.

BY J. N. MARTIN, M.D.,

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WHILE we are not able to speak positively concerning the etiology of membranous dysmenorrhœa, the microscope has made a correct differential diagnosis possible. Without the use of this instrument it is impossible to ascertain whether the mass expelled

from the uterus is dysmenorrhœal membrane, a product of conception, or a blood-clot which has been retained in the uterus and with the fluid portion squeezed out. Experience in treatment has taught us to be guarded in our prognosis. While most cases of true membranous dysmenorrhœa cannot be entirely cured, yet I believe it is equally true that almost every patient suffering from the disease can be materially benefited by careful and systematic treatment.

There is a mass of membrane to be forced through a canal of given size which perhaps is sufficiently large for the fluid menstrual secretions to pass without causing pain, but not large enough to permit the abnormal formation to pass without much expulsive effort and consequent pain. Again, if the disease has existed a long time, there is more or less inflammation of the uterus which adds inflammatory to membranous dysmenorrhœa. And again, this extreme suffering accompanying the condition produces a marked effect upon the nervous system; and so great is this result in some patients that they become nervous or mental wrecks. Then by treatment we should strive to prevent the formation of the membrane or to favor disintegration at the time of the menstrual period, and also to get rid of the results. Not understanding the cause of the formation, we are working in the dark in endeavoring to get rid of it.

While there are many forms of treatment, I have had satisfactory results with the following plan:

First. To relieve the inflammation of the uterus as much as possible between the periods with prolonged hot-water douches once or twice daily; applications to the interior of the uterus two or three times per week of equal parts of 5 per cent. solution of carbolic acid and Churchill's tincture of iodine; and also the use of tampons saturated with glycerin, hydrotis, or boro-glyceride (10 to 20 per cent. solution).

Second. To correct constitutional disturbances and give nerve and general tonics. Bromides and similar agents generally make patients worse in the end, and I never resort to opiates except in the most extreme cases.

Third. To divulse the cervical canal from five to seven days before the time for the period; repeating for two or three months: thus making the canal so large that the membrane may be passed with but little expulsive force. Sometimes after divulsing, inflammatory pains are slightly worse for one or two periods, but in the end it benefits in a majority of cases.

Fourth. To prevent the formation or to favor disintegration, I scrape the uterus thoroughly with a dull curette in the middle of the inter-menstrual period, and afterward apply 1 : 300 or 1 : 400 solution of bichloride of mercury to the interior of the

uterus once in three or four days, and repeat for from two to five months, as may be indicated.

I have followed this plan for about four years, and can say with truth that I have considerably benefited every case excepting one. Two cases were entirely cured; at least it has been more than a year since one of them passed any membrane, and nearly a year since the other did so.

The one patient not relieved does not pass a membrane every month: about every third month there is no membrane expelled, but at each period following the omission, she passes two membranes one within the other. On January 15, 1889, I presented this patient in clinic, with a double membrane expelled, and also another patient with membranous dysmenorrhœa who happened to be in the University of Michigan Hospital for treatment. Five patients with well-defined membranous dysmenorrhœa were presented to the class last year, and I saw two others in private practice.

PHTHISICAL PATIENTS AT CLIMATIC RESORTS.

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MEMBER AMERICAN CLIMATOLOGICAL ASSOCIATION, MEMBER AMERICAN
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DISEASES OF THE LUNGS AND THROAT, ETC.

It would be most instructive if accurate data could be obtained of the benefit derived from the climatic treatment of phthisis, and particularly so if we could get at the number of real cures which result therefrom. But, as with any other method of treatment which we carry out in our daily practice, it will ever be more or less difficult to ascribe to the means employed their proper value, and after the result is known it may always be conjectured that if this or that had been done the outcome would have been different.

Much of our therapeutical knowledge is empirical, and this is particularly true of our resources in the treatment of consumption. Climate has stood the test of experience for centuries, and is to-day still recognized as, perhaps, the most valuable of all the means available in our battle with this disease, not only by the profession, but by the laity as well, and what everyone believes must contain at least some truth. I am far from underestimating the value of climate, the beneficial influence of which I daily see convincing evidence. Do we not see, almost at once, improvement in one or several directions, with the arrival of many such patients—a steadily falling pulse-rate, diminution of cough, expectoration, and fever, increase of the appetite and assimilation, and gain in body-weight, especially if the patient is at once put upon a proper regimen? Besides, there are many undoubted cures on record at such climatic resorts, and, although not accessible

to statistical demonstration, the proportion, as compared with most painstaking management at less favorable localities, is such as to remove all doubt from the mind of the unbiased observer in favor of the climatic treatment of phthisis.

I have, however, also observed that the disease is curable in less favorable localities, even where it is very prevalent, and that under proper management much better results than the usual can be obtained, comparing, indeed, most favorably with climatic treatment as usually carried out, or, at least, with the results which I have been able to observe, when climate was chiefly relied upon for a cure.

If, then, climate has any value at all, the results must improve in proportion as we carry out, in addition, the management which is found valuable in the absence of a favorable climate, and this, too, my experience has verified. In gaining such experience I have guarded myself as well as possible against erroneous conclusions, and have based them, in the first place, upon a comparison with my results obtained at what must be considered an unfavorable locality, and again, upon results in cases which I considered under proper management in addition to climate, and still others, under the same climatic advantages, but treated under conditions where it was impossible to enforce the essential regimen.

Anything which, in view of the great mortality, can contribute ever so little to better results, or which may be honestly believed by a careful observer to have so contributed, deserves the careful attention and consideration of the profession, and obviates the necessity for an excuse in bringing up a subject so much debated and written upon as is the one under consideration.

Believing as I do, that the conduct of the patient while undergoing climatic or any other mode of treatment, other things being equal, is responsible for success or failure in almost all cases where there is still reasonable ground for hope, and that such conduct, either through ignorance or wilful disregard of advice, is faulty in the great majority of cases which I have observed; and believing, also, that I have had unusual opportunity for observing, it is my object to point out the things that such patients do, or do not do, to their detriment, so that a more watchful care, more pointed advice, and stronger reprimands will be administered by those who assume the duties of medical adviser to these unfortunate sufferers.

This watchful care, this continuous exhortation to the path of duty, these frequent reprimands for commission or neglect, or the words of approval for painstaking compliance with our orders and advice, make up much or all that is essentially proper management, providing, of course, that the advice itself is sound and proven by experience to be the best.

Many patients have little will-power to begin with, and as disease has still further reduced it, they flounder on the slightest occasion; many others have become wise in their own conceit, have borrowed medical books and read up their case, know a great deal, and like to play their own doctor, or argue the case with their physician; others listen to the advice of every quack medical advertisement, or any advice backed by a story of wonderful recovery; others still, expect miraculous results in the course of a few weeks or months, and are most easily discouraged. All these to be benefited at all require strict supervision and management in a well-conducted institution. Most difficult they are to manage, even there; and, if the whole *clientèle* in an institution should be made up of such material, may the Lord have mercy upon the managing physician!

There are, fortunately, a goodly number of sensible and reasonable patients who are willing and anxious to profit by our advice, whom we can trust in all ways, and who, if they err, do so only from ignorance. Such patients do well outside of institutions, also, and with the exception of the advantage of prompt aid, should any complications arise, they are as well off in private practice, provided the physician can see his patient frequently, and the conditions of hygiene, proper diet, rest, etc., are equally good.

But to come to the faulty conduct of phthisical patients at climatic resorts: First, most of them do not wish to admit that they are sick—they have come for a change only, and endeavor to play the rôle of a well person; they say that their physician has told them that there is "nothing really the matter with their lungs," being only "weak," or that they have only bronchitis or throat trouble. All this leads them to a feeling of security or to expect that the climate "will fix everything" in a short time.

I contend that the physician who sends away a phthisical patient for climatic treatment sends a sick person, no matter how early the stage of the disease, and that this patient needs competent care, supervision, and advice from the day he reaches the climatic resort until he is cured; unless this is the case he will, in all probability, derive little or no benefit. A patient who is to recover should be made to understand by his physician that it takes a considerable length of time, even in the early stages, to effect a cure; that it will cost not a little money, and that a few weeks or months are entirely inadequate. All this can be done without depriving the patient of hope for his restoration.

Second. The patients who are at all able to undergo climatic treatment come from a class who have comfortable homes, good beds and food, and live in houses well heated, with inside water-closets

and baths; and, finding prices higher than they anticipated on leaving home, frequently go to cheap boarding-houses, where they forego many comforts and conditions absolutely essential to their favorable progress. If anything, better conditions than those to which the patient has been accustomed should be secured, and to get them at health resorts, which are far distant from centres of supplies, means increased expenditures over what would be required for the same accommodations at home. Patients who are sent away should be made to understand this, and that a few dollars expended to get the necessary accommodations are well invested.

Third. Upon arrival at climatic resorts the amount of out-of-door life and exercise requires careful regulation, and it must depend entirely upon the conditions existing in the individual case. But many come only with the idea that the more exercise they take the better, and instead of judicious rest after their journey we find them out bright and early after their arrival, on a hunt for boarding-houses, often on foot, the fatigue which should be avoided frequently amounting to actual exhaustion, and there are cases where the first day spent in the manner described leaves effects never to be recovered from. After being settled they continue to exercise far beyond their strength and endurance, taking unaccustomed horseback rides, with parties of well-trained riders, ascending mountains when exercise on level ground should be limited, and all this regardless of fever or other complications. At night they visit clubs, play cards, dance, and follow their inclinations for amusement, which, perhaps, permissible within reason for some, can only bring disaster to others; they then find that the looked-for improvement in appetite, etc., has either not been realized at all or been very transient, and they begin to doubt the judgment of their home physician who recommended the climate.

Fourth. No case should endeavor to work out his improvement or cure at a climatic resort without professional oversight. This is a delicate point for physicians to urge who practise at such resorts, and I content myself by quoting at length Dr. Clifford Allbutt,¹ from Dobell's monograph on the initial stages of consumption:

"Let us, then, bring the friends always and the patient generally to realize that recovery from phthisis, however incipient, probably means a very costly and prolonged system of treatment, and, what is more, a steady, clear-eyed persevering walk on the part of patients and friends, if success is to be obtained. Now, when a man has had it put straight before him what phthisis means, even in its small beginnings, he will learn that a serious, an unflinching and vigilant attitude is his only way of safety; and a little homesickness, some sense of tedium, and some love of change must not be allowed to turn him from his long and arduous course. Once more I would

¹ Lancet, October 13, 1888.

urge on all phthisical patients the importance of incessant medical supervision. Apart as I am from practice in Alpine health resorts, I may brush aside all scruples, all suspicion of self- or class-service, in saying this and repeating it. For those medical men who do practise in these health resorts there must be a fear of misconstruction of their motives when constant supervision seems to them more necessary than it may seem to the patient or his friends. But scruples of this kind, honorable as they are to the physician, must give way to a clear view of the need of such supervision. The patient must be kept at his best—at the best of his digestion as well as at the best of his pulmonary disorder. His temperature should be again scheduled whenever any sense of lassitude is felt, and the catarrhal or other varying conditions of the lungs should be systematically recorded. Not only so, but the regular visits of his doctor keep up the patient's serious resolve, strengthen his will, inform his judgment, and discipline his habits. And in all this lies most of the battle."

These, Dr. Dobell says, are the wise and considerate words of an unusually wise, experienced, and independent practical physician. Dr. Allbutt has applied them to cases of phthisis, even in its early stages:

"They apply to it more and more strongly as we go further and further back in its small beginnings to what I wish to be emphatically recognized as the smallest of all beginnings, its true first stage, its pre-tubercular stage, its stage of comparative simplicity and of comparatively easy cure."

But if this is all true, as it no doubt is, what is to be said of the needs of the cases who are well advanced in the early stage, who are upon the confines of the second stage, and in whom still a fair percentage of recoveries or rather permanent arrest of the disease is possible?

As a rule, medical men who practise at resorts are not consulted by patients sent there unless some complication arises, or when the patient himself fully realizes that he is getting worse instead of better, as he had expected. The complications passed, the regular attendance ceases until the next relapse again requires professional aid or advice.

Under such conditions no painstaking physical examinations are made matters of record for future comparison, and the regimen and advice are adopted only for the exigencies of the time being. Under such conditions not much progress is possible, but, if any is made, it is, as a rule, undone by some indiscretion.

Take, however, the cases of patients exercising little control over their inclinations, who suffer so frequently from gastric and intestinal derangements due to errors of diet; take those who, in the state of advancing disease or softening processes, suffer from more or less continuous fever; the cases with repeated slight or more severe hæmoptysis, or cases with frequently recurring pleuritis; take cases with tubercular laryngitis, with nasal catarrh, and stenosis—how are all these to get on under self-management?

Fifth. Phthisical patients, as a rule, give up climatic treatment and professional management at a period when arrest of the disease is but temporary, and when, if possible, the efforts should be doubly rigid and vigilant to make such arrest a permanent one and an actual cure. They mistake the attending improvement in general health, the returning strength, for evidence of cure, and propose to let the little remaining cough wear itself out at home. Ninety-nine out of one hundred of such cases relapse sooner or later, and regret bitterly enough when it is too late that they abandoned perhaps their last or only chance. Such patients, if under medical care at all, do not consult us often as to the propriety of their course, unless with the expectation of following it even if we should dissent. As a rule, they tell us that they think they are well enough to go home, or they have come for so many weeks or months only and the time is up. Many times our remonstrances are less strong for fear that our motives may be misunderstood; and for better results in all these matters nothing can have a greater influence than the home physician's support and advice.

Some climatic resorts have the disadvantage of being available only for certain periods of the year, and, of course, changes from such to others are necessary with change of season. But Asheville, although possessing a most favorable all-year climate, has, nevertheless, much the same seasons of exodus and arrivals as do the strictly winter or summer resorts. The class who come here in the fall and winter pack up for home in the spring; those who come in the spring and summer (until recently, as a rule, from Southern States) make room for the winter guests. I consider this most detrimental. It takes, usually, several months, or even more, to make any decided gain, and just as the prospects become the best and the chances for a cure have greatly improved, the patient interrupts the favorable progress to go home, or somewhere else, for a season. I strongly contend that a patient who has made real improvement at a climatic resort, and if the conditions of climate are favorable throughout the year, should, under no consideration, attempt a change until a permanent result is obtained.

Finally, it is deplorable that so many far advanced cases are allowed to leave the comforts of home and friends in search of what they can never find. I suspect that many medical men permit these straw-grasping efforts because, in the kindness of their hearts, they are unwilling to deprive the sufferer of this last hope. I doubt if they really do him a kindness. Far better to urge on the early cases—those "in the small beginnings"—so that the necessity will occur less and less frequently of sending them home almost exhausted or dead.

It is chiefly the home physician who is to decide

what the percentage of recoveries shall be from climatic treatment. Early diagnosed, early sent, properly instructed, and the physician at the climatic station supported in his efforts to enforce a discipline which will result beneficially, are the essentials if we wish to take advantage of every means in the interest of the phthisical patient, who, otherwise, is almost sure to go astray, and whose recovery becomes thus more and more a matter of chance and accident.

OESOPHAGOTOMY FOR IMPACTION OF ARTIFICIAL TEETH.

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THE patient, a white man, aged twenty-seven years, was admitted to the insane department of the Philadelphia Hospital in the early part of July, 1889, with the following history: After an alcoholic debauch, lasting three weeks, he became so unmanageable as to require removal to a police station, where he was placed in a cell. While there he fancied that demons were preparing to kill him, which led him to attempt suicide by striking his head against the wall. A few days later he was taken by the police authorities to the hospital.

On admission examination of his face and scalp showed many contusions. He complained of sore throat, was unable to swallow solid food, and could with difficulty swallow a small quantity of liquid. There was profuse, purulent, and offensive expectoration. Examination of the mouth showed an acute pharyngitis, also the absence of a number of teeth from the upper jaw. In the centre of the hard palate was a prominence of mucous membrane like that made by the plate of false teeth. He casually remarked that he had lost his teeth. Local treatment was given for the pharyngeal trouble, with no effect. A probang passed into the oesophagus demonstrated the presence of a foreign body at a distance of about two inches from the commencement of the tube. Having recovered from the effects of the alcohol he was apprised of his condition and advised to have whatever interference might be necessary for the removal of the foreign body, which was most probably the missing plate of teeth. To this he consented, and accordingly I made an attempt to remove the foreign body with a pair of long, well-curved forceps. With them I could reach the body, but was unable to grasp it, and before adopting any other procedure I had the patient etherized. Under complete anaesthesia a second attempt with the forceps was made, but with the same result as before. I now tried to dislodge it with the oesophageal probang, but it was so thoroughly fixed that I was not

able to accomplish anything. There was then left but one course for me to pursue, that of opening the oesophagus at the side of the neck. The patient was placed with the head inclined to the right side, the left side of the neck being selected through which to make the incision, and the shoulders raised upon a pillow. An incision, commencing at the sterno-clavicular articulation, was carried through the skin to near the angle of the jaw, when the anterior jugular vein very much distended was seen in the superficial fascia. The vein was ligated at two points and, with the fascia, severed between. The deep fascia was now incised, lifted upon a grooved director and divided to the length of the superficial wound, when the sterno-mastoid muscle with the bloodvessels was displaced backward, the anterior belly of the omo-hyoid muscle downward, and the sterno-hyoid and sterno-thyroid muscles forward. The oesophagus, made prominent by the distention occasioned by the foreign body within, was clearly exposed. Above and below the distended portion of the oesophagus were seen the superior and inferior thyroid vessels. The oesophagus was opened in the line of its longitudinal muscular fibres, when the knife came directly upon a tooth. The wound was then enlarged upward and downward to the extent of two inches, when the plate of a partial set of teeth was exposed lying upside down and crosswise, the front of the plate, containing two teeth, presenting at the bottom of the wound. After a great deal of difficulty I succeeded in removing the plate, and upon removal it was found that a tooth was missing. This was expectorated during the night following the operation, and I have no doubt that it was detached during the extraction of the plate. The wound in the oesophagus was closed with catgut sutures, a rubber drainage-tube placed external to it, and the superficial wound closed with silver wire. The patient reacted well and was nourished for three days entirely by enemata of dextrine, eggs, beef tea, and peptonized milk. From this on he was given, in addition to enemata, milk and whiskey, introduced into the stomach by a pliable passed through the anterior nares. The expectoration continued to have the same character as before the operation.

The wound was dressed the third day after the operation, when it presented a perfectly satisfactory appearance. Two days later, the dressing being much soiled, the wound was exposed and a purulent and offensive discharge was seen escaping from and around the tube. The apparent line of union was much inflamed, showing some signs of breaking down. The following day the discharge having soaked through the dressings, they were removed and the wound was found broken down throughout, the tissues presenting a gangrenous surface. Liquids

now introduced in the mouth escaped through the wound. Wound packed with iodoform gauze. On the evening of the sixth day after the operation the patient had a chill, followed by high temperature, rapid pulse, and increased frequency of respiration. Examination of the chest demonstrated the presence of pneumonia of both lungs. On the following day, the seventh after the operation, he died.

Autopsy, made forty hours after death. Examination of abdominal cavity showed the kidneys to be large and intensely congested. Spleen enlarged, soft, and pulpy. Other abdominal viscera showed no gross lesions. Heart and pericardium normal. Both lungs contained innumerable dark-red solid areas, varying in diameter from one-eighth to three-eighths of an inch, which appeared to be peri-bronchial. Examination of wound showed the condition as described at the third dressing. The larynx, trachea, œsophagus, and lower portion of the pharynx were removed in a single mass. On the left side of the œsophagus immediately below the cricoid cartilage, was seen the incision through which the teeth were extracted. The edges of the opening were dark in color and gangrenous; it measured one and one-half inches in length and one inch in width. On the same side of the lower portion of the pharynx was an opening about the size of that in the œsophagus, and presenting the same appearance. Through this opening was seen exposed the left superior cornu of the thyroid cartilage, also the upper border of the cricoid cartilage. Immediately above the cricoid cartilage, a little to the left of the median line posteriorly, was a small opening leading into the larynx. In the extreme lower portion of the pharynx, posteriorly and a little to the left of the median line, was an ulcer one-fourth of an inch in diameter which had perforated the walls. The mucous lining of the pharynx immediately surrounding the openings was gangrenous. On the laryngeal surface of the epiglottis was a small superficial gangrenous ulcer. There were evidences of an active laryngitis, tracheitis, and bronchitis.

I believe the teeth were first arrested in the lower portion of the pharynx, remaining there long enough to set up the destructive inflammation which resulted in the formation of the openings found, and which, coupled with the efforts of swallowing, caused them to be dislodged; they becoming fixed the second time and permanently in the upper part of the œsophagus from which they were extracted.

In the light of the autopsy it is quite evident that the patient could not have lived with any treatment, but the points for discussion in the case of foreign body in the œsophagus calling for operative interference are the following: First. When it is impossible to extract the foreign body through the mouth, but possible to push it down into the stomach, is it not better to do this, providing its character is such as not to lacerate the walls of the œsophagus, and perform gastrotomy, than to remove

it by the operation of œsophagotomy, as the former operation offers a better chance for success than the latter? Secondly. Having done an œsophagotomy is it better to close both wounds, or simply close the œsophageal wound, packing the wound in the neck, or to allow both wounds to remain open? In another case such as I have reported, I would not close either the wound in the œsophagus or the wound in the neck, but would trust to healing by granulation, as I believe in this case drainage was an essential factor which was by no means thoroughly obtained.

THE EMPYREUMATIC OIL OF COFFEE, OR CAFFEONE.

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WHEN coffee is roasted an empyreumatic oil is developed which is supposed to impart to it new physiological properties. The actions of this substance have been studied chiefly by means of a distillate obtained from a strong infusion of coffee; by a comparison of the effects produced by the use of preparations of raw and roasted coffee; or by the administration of the pure oil.

In experiments on three individuals Lehman¹ found that the distillate from roasted coffee caused nervousness and slight sweating, and acted on the brain, affecting the mental faculties rather than the imagination. The solid constituents of the urine, such as urea, were diminished to a greater extent than by caffeine. After large doses there occurred congestion, profuse sweating, and sleeplessness. In two instances diarrhoea was noted. Nasse,² in experiments on animals, states that when he injected a few drops of a strong infusion of freshly roasted coffee into the jugular vein of a rabbit, peristaltic movements of a decided character occurred in the intestines which he was unable to produce with caffeine. Méplain³ obtained from a litre of strong infusion of coffee 200 grammes of a liquid which possessed the aromatic odor of roasted coffee and a slight bitter taste. After the ingestion of this the pulse was increased from 64 to 74 per minute, arterial tension was diminished, and the face congested. Marvaud (*ibid.*) obtained similar results. Rabuteau⁴ states that he has "recognized in caffeine the exciting properties attributed to coffee. Everybody knows that an infusion of coffee hinders sleep, but that this effect is not invariably present. We have wrongly attributed this difference in action to idiosyncrasy, but it is due to a difference in the composition of the coffee, for while an infusion of coffee

¹ Annal d. Chemie u. Phar., 1853, Bd. 87, S. 275.

² Beiträge z. Physiologie d. Darmbewegung, Leipzig, 1866, S. 66.

³ Les Aliments d'Épargne, 2 ed., Paris, 1874, p. 305.

⁴ Compt. rend., lxxi. p. 733.

containing caffeine prevents sleep, the same effect is not produced by the ingestion of an infusion which has been freed from caffeine by prolonged boiling, or by that which has been prepared from coffee too much roasted, or from green coffee, or which contains a small quantity of the particular substance which gives coffee its peculiar odor." He also found that caffeine possesses decided toxic properties, and prevents the development of low organisms in organic fluids. Binz,¹ in experiments on three dogs with a distillate, obtained results in some respects opposed to those already recorded. The distillate, he states, was of a light golden color, of a very aromatic odor and taste, and cloudy when cold. In one experiment a dog, weighing 720 grammes, was given by the stomach 25 c.c., representing the one-half of the distillate from 22 grammes of coffee, in 150 c.c. of hot water. No phenomena were observed, except a quickening of the heart-beats from 110 to 145 per minute. In another experiment with a dog, weighing 1790 grammes, and drunk with alcohol, 12 c.c. of a distillate from 16 grammes of coffee in 1 litre of water were injected subcutaneously in two places. In six minutes the respiration rate was doubled in depth and frequency. In the last experiment the dog weighed 1840 grammes, and was completely narcotized with alcohol. Before giving the caffeine the arterial pressure was 76 mm. of mercury and the pulse 39 in fifteen seconds. Twenty c.c. of a distillate of 85 c.c., which was obtained from 20 grammes of roasted coffee in 100 c.c. of water, were injected subcutaneously, and 50 c.c. given by the stomach. In ten minutes the pressure fell to 68 mm.; in fifteen minutes, to 66 mm., and in forty minutes, to 56 mm. The force of the pulse was doubly strong, and the heart-beats increased in frequency. The diminution of blood-pressure he consequently attributes to vascular dilatation.

It is obvious that in the investigations above referred to, the actual quantities ingested of the so-called caffeine were not known; it therefore occurred to Hare and Marshall² to isolate this substance and study the effects of definite doses. They extracted the oil with pure petroleum ether, and allowed the latter to evaporate spontaneously. The product thus obtained was of the consistency of dilute syrup, varying in color from a light to a dark brown, according to the color of the seeds, and possessing to a great degree the peculiar aroma of roasted coffee. When injected into the jugular vein of a dog the pulse was for a short time increased and then diminished, and the arterial pressure was lowered. If the dose was sufficient to kill, the heart-beats became slower and slower, arterial pres-

sure gradually fell, and the heart was arrested in diastole. The asserted antisoporific properties attributed to caffeine led them to make one experiment on a dog and three on men, in each of which single doses of from 50 to 60 minims were given by the stomach. In the dog and in two men sleep occurred and in one case sleeplessness.

The investigations of Hare and Marshall I have recently supplemented and extended during the progress of a study with caffeine. The oil was prepared in the same manner, and the results obtained from its intravenous injection in dogs were identical. It seemed to me, however, that an oil of such consistency, and which is practically insoluble in the blood, would, when thrown directly into the circulation, mechanically clog up the capillaries in the nerve-centres and elsewhere and thus give rise to serious disturbances. Therefore, in another series of experiments, I substituted for the oil of coffee pure olive oil and obtained similar results. In a third series, in order also to obviate these mechanical effects, the oil of coffee was given subcutaneously in amounts varying from 1 c.c. to 3 c.c. per kilo of body-weight, but without any effect on the heart-beat, arterial pressure, cerebral functions, respiration, or heat phenomena. It is, therefore, conclusive that the empyreumatic oil of coffee, as obtained by Hare and Marshall, is inert.

The positive results recorded by various observers following the ingestion of a distillate from roasted coffee, the evident differences in the activities of infusions prepared from raw and roasted coffee, the change in the properties of the infusion of roasted coffee which occurs from continued boiling or in the seeds by excessive roasting, certainly lead to an inevitable conclusion that some volatile principle is developed during the roasting which is dissipated by prolonged heating and which possesses definite physiological properties. It would, therefore, naturally be inferred that such a substance would pass over in the early distillate from a strong infusion of coffee. I consequently prepared a distillate by placing 500 grammes of freshly roasted coffee in a Florence flask, adding sufficient water to cover it, and collecting the first 200 c.c. distilled. This was of a pale yellow color, slightly turbid, bitter, and had the strong aromatic odor of roasted coffee. A small dog, weighing 6 kilos, whose carotid was connected with the kymographion, was given, by means of the external jugular vein, within ten minutes, 105 c.c. of this distillate in doses of 10 c.c., but without any definite effect on arterial pressure, pulse, respiration, bodily temperature, or otherwise. A similar distillate was prepared from other samples of coffee, but all were inert, although appropriate tests demonstrated the presence of organic matter. The opposite results obtained by different observers

¹ Archiv f. Exper. Path. u. Phar., ix. S. 45.

² THE MEDICAL NEWS, 1888, vol. lii. p. 337.

and myself, lead to the belief that this hypothetical principle is more volatile in some samples of coffee than in others. Whatever may be its nature, it is clearly not identical with the empyreumatic oil which is so abundant in roasted coffee.

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CLINICAL MEMORANDA.

TOXICOLOGICAL.

A Case of Cannabis Indica Poisoning.—On February 15th, at seven o'clock, I was called in haste to see Mr. B., a single man, aged thirty years, and found him almost in collapse, with moist, pale, cold skin, fingers and lips blue, pulse very weak and rapid, respiration slow, mind clear, though excited by the dread of death. He complained of shocks like electricity passing through the body, beginning at the neck. These spasms were so marked that they could be felt by those rubbing his hands and feet. He complained also of burning flashes of heat proceeding from the thorax. He felt them coming, and showed a great dread of death at such times. He also had great difficulty of breathing, with a weak and very rapid pulse, which was scarcely perceptible.

I at once administered carbonate of ammonium and whiskey (no digitalis being at hand), to which he responded very promptly for a short time. His extremities were rubbed with whiskey, and hot-water bottles were applied to his feet.

I then inquired for the history. No similar attack had ever occurred. He had taken a teaspoonful of medicine three-quarters of an hour before, but what it contained he did not know. While at the supper-table the symptoms suddenly came on, and he called to some one to catch him, as he was falling. He had just recovered from influenza, and this medicine was given as a tonic. I excluded fainting, as the mind was clear, then thought of strychnine, owing to the twitching of the muscles, but the heart symptoms did not correspond. I did not give an emetic owing to his weak condition, and because three-quarters of an hour had elapsed since the medicine was taken. After repeating the ammonia and whiskey several times and giving digitalis, which had now come to hand, the symptoms in the course of an hour grew better, and the family physician with another doctor now arrived. On inquiry the doctor said he had ordered 2½ minims each of tincture of nux vomica and tincture of cannabis indica, and 20 minims of dilute phosphoric acid in tincture of cinchona.

We then concluded the druggist must have made a mistake. I withdrew shortly after; the family physician remained during the night, and stated that the patient talked in a rambling way until midnight, with short intervals of sleep, after which he dozed lightly till morning. On going to the pharmacy we found the prescription to be as follows: "Acid phosphoric, dil., tr. nux vomica aa ʒj, tr. cannabis indica ʒvj, elix. calisaya ʒvj, syr. prun. Virg. ad ʒiij. S. one teaspoonful three times daily." The druggist had made no mistake. The cannabis indica was the cause of the symptoms. The doctor ordered the drug on the basis of the American Pharmacopœia, which directs the tinc-

ture to be made from the powder, while the prescription was put up on the basis of the English Pharmacopœia, in which the tincture is made from the extract and is much stronger. The English drug is more stable than the American, and here, where the drug comes directly from India, it is still better. The teaspoon used held more than a drachm, so that the patient must have taken at least the equivalent of one grain of the extract. It probably would not have produced such dangerous effects had the patient not been of a nervous disposition and much weakened by the influenza.

The heart failure shown in this case is not mentioned in the text-books as a symptom of hemp poisoning. It is curious that the drug did not act as a hypnotic, and that it did not produce that apparent prolongation of time that is ordinarily spoken of. Great weakness remained, especially of the lower extremities, so that he was a week regaining the condition that he was in before the poisoning.

The above proves that it is important:

1st. To follow the repeated warning given in the text-books that such a drug should be first used in minimum doses and increased as indicated.

2d. That toxic drugs should not be prescribed in a foreign country unless one is familiar with the strength of the preparation according to the Pharmacopœia of that country.

3d. That we should not prescribe a dangerous drug when there is no indication for it.

S. P. GLOVER, M.D.

BEYROUT, SYRIA.

MEDICAL.

Salicylate of Sodium in Typhoid Fever.—In THE MEDICAL NEWS of December 14, 1889, Professor George L. Peabody, writing on typhoid fever, says: "It would seem that any one possessed of facts bearing upon the subject, need offer no apology for presenting them to his brethren," and as my mode of treatment is altogether different from any other method that I have seen described, and is gratifying in the extreme, I here present it for acceptance or criticism.

Living in a small town, and doing an extensive country practice, it is impossible to take the temperatures of my patients at stated hours, for they are frequently ten miles apart.

During the past year I have treated about twenty cases of typhoid fever, with but one death. This patient, a lady, of thirty-five years, had taken large and repeated doses of podophyllum for ten days before sending for me. She died of intestinal hæmorrhage soon after I saw her. Four cases were children, between five and ten years old, the remainder adults. To the latter I gave daily twelve grains of the salicylate of sodium every two hours until four doses were taken; this amount (forty-eight grains) reduced the temperature promptly in every case save one with hepatic symptoms, who received ten grains of calomel in two doses. After the function of the liver was reëstablished in this case the salicylate was, for a few days, efficient in controlling the fever. Afterward it seemed advisable to assist its action with spirit of nitrous ether. If the skin is hot and dry, the sodium salicylate produces free diaphoresis in from one-half to one hour after the first or second dose. The pulse becomes softer

and diminished in frequency. It is occasionally necessary to give a few doses of fifteen grains each, but this amount should not be continued, as such large doses cause symptoms of depression. To some patients I gave four drops of the tincture of digitalis every four hours, to prevent cardiac depression. Turpentine was applied to the abdomen of each patient, and was rubbed upon the legs, soles of feet, arms, shoulders, or lumbar region when aching in the limbs or back was complained of. In a few cases, where tympany was marked, ten drops of turpentine were given every five or six hours. When diarrhoea was excessive I gave the following mixture:

Tincture of myrrh	1 ½ ounces.
Tincture of capsicum	½ ounce.
Tincture of catechu } of each	1 " —M.
Tincture of opium }	

One teaspoonful every two or three hours.

Calomel, in my opinion, is not indicated unless so-called bilious symptoms are present. In such cases it is useful, but if given *late* it is potent for harm, and I should hesitate to give it after the tenth day. Cold or tepid water should be applied to the hands and arms if fever be high, and the back may be sponged and fanned if the patient experiences no discomfort from it.

The diet should be restricted to milk, or meat broths containing a small amount of farinaceous substance. An enema of warm water, or a suppository of soap, is sufficient to move the bowels if they become constipated, but they should not be used oftener than every fourth or fifth day.

With the above treatment I have never seen the fever continue longer than eighteen days, and have often limited it to less, and even aborted it entirely. If quinine be a specific for intermittent fever, I believe that salicylate of sodium is for typhoid fever. A child of one year can take two grains; of five years, five grains; and of seven years, ten grains.

Given as above it will control fevers, and why it has not been used before cannot better be explained than in the language of Professor William Goodell, who says: "Truth evolves slowly, and does not, like Aaron's rod, bud and blossom in a night."

W. T. SPEARS, M.D.

RUTLEDGE, GA.

HOSPITAL NOTES.

TREPHINING THE SKULL FOR EPILEPSY. EXCISION OF A SPINA BIFIDA. EXCISION OF AN EXOSTOSIS OF THE FEMUR. DOUBLE CASTRATION.

Abstract of a Clinical Lecture delivered at the Roosevelt Hospital, New York.

BY CHARLES MCBURNEY, M.D.,
ATTENDING SURGEON.

CASE I.—The first case for operation was one which had been sent by Dr. M. Allen Starr. The patient, a man thirty-one years of age, fell from a moderate height when nine years old, and received a scalp wound on the left side of the head near the junction of the parietal and occipital bones, two inches to the left of the vertex. No more serious injury was discovered at that time and the wound healed without the development of any cere-

bral symptoms. For the next fifteen years his health was excellent, when he was suddenly seized on awakening from a nap with a violent epileptiform convulsion. This was the first convulsion he had ever had, and it came without premonition. Convulsions then recurred at intervals of about a week, but they rapidly increased both in frequency and severity so that recently he has had as many as thirty or forty every month. The attacks begin by an uncomfortable sensation in the epigastrium which is quickly followed by entire loss of consciousness, twisting of the head and shoulders toward the left, and then a general convulsion of the muscles of the whole body. The attacks usually last fifteen or twenty minutes and are sometimes followed by very violent delirium. He has received for a long time the usual medicinal treatment for epilepsy, but without any benefit. Examination showed a slight scar on the left side at the site already mentioned, and some inequality of the bone underneath. Pressure on the scar caused a muscular tremor all over the body.

His case seemed to be a favorable one for operation:

- (1) Because the frequency and severity of the seizures were like those often seen in traumatic epilepsy;
- (2) the treatment for ordinary epilepsy had proved ineffectual;
- (3) the increasing frequency of the attacks indicated a direct source of irritation; and
- (4) on account of the peculiar effect of pressure upon the scar.

A curved incision was made so as to expose a large area of bone. The bone anteriorly showed only a slight groove, and posteriorly a very superficial circular depression. A button of bone was removed by trephining from both of these situations, and the bone cut away so as to unite these two openings. There was no evidence of injury upon the inner surface of the bone, but the dura bulged markedly into the opening. After incising the dura palpation of the brain showed it to be much softened over an area about one and one-half inches in diameter. The softened portion was removed with a sharp spoon and by sponging, and beyond this on all sides the brain appeared normal. Two small rubber drainage-tubes were inserted and a portion of the wound sutured with catgut. The remainder of the wound was packed with iodoform gauze and a large antiseptic dressing was applied.

CASE II.—A woman with a rather puzzling cystic tumor of the buttock was next presented for operation. According to her statement the tumor made its appearance about seven years ago, and, she thought, was the result of a blow. It grew rapidly to about the size of a lemon, when it was removed by operation; but within a year returned. The tumor was at present the size of an orange and was situated just over the base of the sacrum. Its size varied greatly with the position of the patient, so that Dr. McBurney suspected that it might be found to arise from the pelvis.

An incision was made over the tumor and a little dissection showed that the cyst passed into the sacrum through a foramen in the median line measuring about one and a half inches long by one inch broad. Finding it to be a spina bifida the dissection was carried down until a pedicle about the size of a goose-quill was reached. It was then ligated at this point with catgut and excised. Though the patient was positive that there had been no tumor in this region before her twenty-

fourth year, Dr. McBurney thought that a small spina bifida had probably always existed, and that its growth had been more rapid after the injury. A rubber drainage-tube was inserted and the greater part of the cavity closed by buried catgut sutures. The antiseptic dressing was applied and retained by a double spica bandage.

CASE III.—The next patient was a girl twelve years of age, who had an exostosis on the inner anterior aspect of the femur, projecting about one and one-half inches from the bone, just above the junction of the epiphysis and the shaft. These exostoses occur almost invariably in young people, and very commonly in the locality indicated, probably on account of the great activity of bone growth at that point. It had given her only slight inconvenience, but any traumatism of the part would readily lead to troublesome inflammation of the bursa situated in front of the bony projection.

The base of the exostosis was exposed by an incision, and was then removed, together with the surface of the shaft on which it was implanted, by means of a chisel. If a part of the shaft had not been removed recurrence would be probable. Drainage for the first two days was thought necessary, and the limb was bandaged to a straight posterior splint provided with a foot-board.

CASE IV.—Dr. McBurney then presented a man with tubercular degeneration of each epididymis, which was rapidly advancing, although the spermatic cord on each was still free from disease. There were no evidences of tubercular deposits in the lungs or elsewhere. Dr. McBurney proposed to perform double castration with the object of preventing the advance of the disease along the cord and vas deferens to the bladder, prostate, and surrounding parts. He has never seen any ill-effects from removing organs so diseased, although some operators claim that disease in other parts of the body would be produced by such surgical interference. On the contrary, it has been his experience that where the disease has not advanced too far, the removal of such suppurating foci, whether in this locality or elsewhere in the body, is invariably followed by improvement.

MEDICAL PROGRESS.

Technique of the Porro-Cæsarean Operation.—In an address before the Southampton Medical Society, MR. LAWSON TAIT gave the following clear description of the various steps of the Porro-Cæsarean operation: The instruments required are two or three pairs of catch forceps for arresting bleeding points, a small sharp scalpel, two or three bayonet-pointed suture-needles, some silk, a piece of India-rubber drainage-tube, and two needles of steel wire, and none better than the ordinary stocking-knitting needle can be found. A *serre-nœud* may be added, but it is not in the least degree necessary.

The first step in the operation is the abdominal incision, four inches in length, involving the skin and muscles down to the sheath of the rectus, all of which ought to be divided by a sharp knife at one stroke; then the tendon of the one or other of the recti is opened, the muscular tendons fall aside, and the posterior layer of the tendon is nipped by two pairs of forceps and divided between them. The extraperitoneal fat is treated similarly, then the peritoneum is raised by two pairs of for-

ceps, a slight notch being made between them. The moment this is effected air enters, and all behind falls away. No director is required, nothing but an observant pair of eyes, lightly applied forceps, and a sharp knife delicately applied. The finger is then introduced into the peritoneal cavity, and the relations of the uterus and bladder exactly ascertained. The peritoneum is then opened to the full extent of the four-inch incision, and the cut edges are seized on each side by a pair of forceps and pulled to their respective sides. No better retractors can be employed.

The piece of India-rubber drainage-tube, about eighteen inches or two feet long, is now held as a loop between the fore- and middle-finger of the left hand, slipped up over the uterus and pulled down over the cervix, passing the fingers behind the cervix to see that coils of intestine are not included. One hitch is then made on the tubing when it has been placed as far down as possible, and it is pulled as tight as is consistent with safety. The second hitch may be made in it, but what is far better, an assistant keeps the tube on the strain, so that the one hitch will be quite enough.

A hole just large enough to admit the finger is then made in the uterus; if it is possible, the position of the placenta may then be ascertained; if not, the right fore-finger is inserted, and between the two, by gentle rending, a larger aperture is made in the uterus, and the leg of the child is seized. The fœtus is then carefully delivered feet first, which, despite all authorities to the contrary, is by far the best proceeding; less blood is lost, and it requires but very gentle manipulation to relieve the head.

As soon as the fœtus is removed, the placenta is sought for, and removed in a similar manner. The uterus itself, being then completely contracted by this time, is pulled out of the wound, and the elastic ligature is tightened once more, and the second hitch is applied. The main details of the operation are now completed; all that is required is to pass the needles through the flattened tube and the uterus, and out at the other side, forming a St. Anthony cross, or two parallel bars, to support the weight of the uterus and the stump, and to keep it outside the wound. A complete toilet of the peritoneum is then made, not forgetting the anterior vesical *cul-de-sac*, and stitches are passed in the ordinary way to close the wound accurately round the uterine stump.

The uterus is now removed close down to the needles and strangulating rubber tube, leaving a little tissue above. A little perchloride of iron is then rubbed gently over the surface of the stump; it is dressed with dry lint and some cotton gauze, an ordinary obstetric wrapper is put on, and the operation is at an end.—*British Medical Journal*, March 22, 1890.

The Treatment of Typhoid Fever by Prolonged Immersion.—At the close of a lecture upon the above subject (*Lancet*, March 29, 1890), DR. JAMES BARR drew the following conclusions: 1. So long as the fever is mild there is no necessity for interfering with the temperature, and there is more to be lost than gained by attempting to produce continuous apyrexia. In continued fevers with a persistent high temperature and no marked intermissions, there is no period for building up tissue, and hence it is important to moderate the intensity of the pyrexia,

and, if possible, produce a prolonged daily remission, with a reduction of temperature to at least 100° or 99° . The reduction should be obtained not only by abstracting heat but by limiting its production, and this is the action of baths.

2. Immersion causes a marked improvement in the vaso-motor tone; the bloodvessels become smaller, the pulse slower, fuller, and of improved tension. The heart maintains its vigor, and the only cases in which the sounds have become weaker were those which were not put in the water until a late stage of the fever.

3. The respirations lessen in frequency; the bronchitis and congestion of the lungs improve, and soon disappear.

4. The improvement is, perhaps, more marked in the digestive tract than anywhere else. The tongue becomes moist and clean, salivary secretion increases, appetite and digestion improve, and the diarrhoea not only lessens, but the character of the motions changes for the better.

5. The effects on the nervous system are excellent, delirium disappearing, and the general well-being of the patient improving.

The Treatment of Laryngeal Tuberculosis.—DR. J. NEUMANN has communicated to the Royal Society of Physicians of Buda-Pesth an account of his experience in the treatment of laryngeal tuberculosis. A solution of one-half per cent. of sulphate of zinc, mixed with one to two per cent. of cocaine, was useful in catarrh of the larynx and trachea in tuberculous patients. Sixty cases of extensive tuberculous ulcers of the larynx were treated with insufflations of iodoform, with the result that the ulcers became clean and partly covered with epithelium. No cure, however, was obtained. The anodyne effect of the iodoform on tuberculous ulcers was often surprising. A rather large quantity of the powder should be insufflated. Iodol, mixed with equal parts of boric acid, was a milder application, which had proved serviceable in 300 cases. A twenty per cent. oily solution of menthol was not well borne, and had no great effect. In the final stages of the disease the application of from five to fifteen per cent. of cocaine was useful, especially as enabling the patient to swallow with comfort. Eight minutes after the third brushing, he began with antiseptic insufflations in order to make the effect more complete. Morphine mixed with pulverized acacia, or iodol-boric acid, was used more rarely. Ice poultices and ice pills also effectually relieved pain. Of fifty patients treated with lactic acid, three remained well for a long time, while about thirty were relieved to a certain extent, but relapsed and died. The lactic acid was never hurtful, but was only useful in ulcers. Circumscribed infiltrations must be scraped away with the sharp spoon, if the patient is strong enough to bear it. In advanced ulceration, severe treatment should not be employed. With regard to tracheotomy, Dr. Neumann shared the opinion of Schmidt, that the favorable effect of the operation is due to the increased inhalation of oxygen and the rest given to the diseased organ. Of eleven patients operated upon, six died, four of whom were *in extremis* when admitted; five remained alive. One of these patients had now been under observation for two years, and another for one year.—*British Medical Journal*, March 29, 1890.

Camphoric Acid in the Night-sweats of Phthisis.—Camphoric acid, which is produced by the oxidation of camphor by an acid, has been given by DR. LEU (*Wiener medicinische Blätter*) to thirteen patients suffering from night-sweats—fifty-five doses in all. Perfect success was obtained in sixty per cent. of the cases; partial success in eighteen per cent. The average dose was thirty grains, although in some cases this dose was increased to forty-five or even seventy-five grains, thirty-five to forty-five grains being given in the evening, and about thirty grains in the middle of the day. A remarkable fact was that sometimes the favorable influence of the camphoric acid was not noted until the evening after its administration, while, further, the good effects persisted for several successive evenings. In order to make a comparison with a remedy which possesses great repute in the treatment of night-sweats, the author administered atropine to six different cases in twenty-four instances, alternating each evening with camphoric acid. It appears from these experiments that perfect success was obtained in but forty-two per cent. of the cases treated, atropine thus falling below camphoric acid in efficacy; while, further, even in the cases which were favorably influenced by the atropine, the duration of the effect was not to be compared with that of camphoric acid. Moreover, the after-effects of camphoric acid are quite insignificant, which cannot be said of atropine. In some cases the patients attributed a certain amount of soporific effect to the action of camphoric acid, although this, perhaps, was attributable to the fact that the suppression of the sweat removed a cause which ordinarily would tend to disturb sleep. The author has also made a number of experiments upon the effects produced by the external application of alcoholic solutions of camphoric acid. In one patient, who suffered from marked local sweatings, the substance was locally applied, and seemed to be extremely efficacious.

Though the drug has not a very unpleasant taste it was given by Dr. Leu in capsules.—*Therapeutic Gazette*, April 15, 1890.

The Significance of Albuminuria.—DR. GOODHART, in a paper read before the Harveian Society of London, detailed his observations upon 272 cases of albuminuria which had come under his notice in the past ten years. He called special attention to a form of congestive albuminuria, in which the patient complains of a certain amount of ill-health, whilst on inquiry it is found that he eats and drinks too much, takes no exercise, and probably has gouty antecedents. The urine in some cases is of high specific gravity, and contains only a small amount of albumin. The treatment of such cases consists in the periodical administration of a purge, and in making the patient live according to the ordinary laws of health. Such cases are clearly not due to nephritis. A temporary albuminuria in females may sometimes be explained by the fact that the urine has become mixed with leucorrhœal discharge, whilst in the male the seminal and prostatic secretions may produce a similar result. In cases where albuminuria follows scarlatina, and is therefore presumably due to nephritis, and the patient continues in good health, Dr. Goodhart thinks the phenomenon is to be explained by supposing that each organ has a margin of working power which can be

temporarily encroached upon without bad results. Dr. Goodhart considers that slight and transient albuminuria in a young person is of very little importance, but if the quantity of albumin is large, if it is persistent, or if it frequently reappears, it must be regarded as a danger signal, and is, in some cases at least, due to patches of inflammation in the kidneys.—*Practitioner*, April, 1890.

Menstruation after Oophorectomy.—The question of the cause of menstruation continuing after removal of the ovaries is still an open one. Dr. ENGELMANN (*Annals of Gynecology and Pædiatry*, April, 1890), after a study of the subject, concludes:

1. That the continuance of menstruation after removal of both ovaries is due to remnants of ovarian stroma left *in situ*.

2. That particles of ovarian tissue, however small, which remain after the removal of the greater portion of the organ, whether or not the Fallopian tube be preserved, may retain their activity and continue the functions of the entire organ, and from this we infer that menstruation is more or less intimately associated with ovulation, and that the menstrual condition indicates the ovarian status, provided the uterine tissues be normal in character.

3. That even elongated pedicles may contain ovarian stroma in which the functional activity of the organ may be continued.

4. That remnants of ovarian stroma do not necessarily preserve their vitality and functional activity.

5. That the ovary is an essential factor in the functional life of woman, and that menstruation is inseparable from ovarian activity, if not from ovulation.

The deductions of practical value to the operator are as follows:

1st. If menstruation is to be checked and the change of life produced, it is requisite that every particle of ovarian stroma shall be removed, if the result desired is to be expected with certainty.

2d. If shrinkage of fibroids, limitation of hæmorrhage, or cessation of annoying symptoms is to be accomplished with the greatest possible certainty, both ovaries must be completely removed.

3d. In the performance of double ovariectomy in women not beyond the climacteric, and not suffering from uterine reflexes, such healthy ovarian tissue as may exist should be spared in order that functional activity may not be impaired.

The Therapeutics of Codeine.—Dr. LOWENMEYER, of Berlin, reports his results with the use of codeine (*Internationale klinische Rundschau*, April 6, 1890) in 400 patients, in some instances the drug being given for a considerable period. The effect in many painful conditions, such as gastralgia and colic, was most satisfactory, pain being subdued and the patient falling into a sleep. It was difficult to determine what kinds of pain were most favorably influenced by codeine, but it was apparently of least benefit in cases of very severe paroxysmal pain, such as gall-stone and nephritic colic.

In such affections of the respiratory organs as phthisis, pleuritic pain, bronchitis, and pneumonia, good results were obtained from codeine. It also rendered excellent service in asthma. The author's experience shows that it may be given without fear where there is cardiac dis-

ease. The doses employed by Lowenmeyer varied from $\frac{1}{4}$ to $\frac{1}{2}$ grain.

Fluorescein in the Diagnosis of Corneal Lesions.—Dr. R. L. RANDOLPH, in the *Johns Hopkins Hospital Bulletin*, April, 1890, details his results in the diagnosis of corneal diseases with fluorescein, as described by Dr. Straub, who states that corneal abrasions are temporarily stained a deep green by solutions of this compound.

Fluorescein is a red powder, soluble in water, and is one of the products of coal-tar distillation. Dr. Randolph employs a solution of 10 grains of the powder to the ounce of water, to which are added 15 grains of the bicarbonate of sodium.

He has never known the solution to have an irritating effect, and has used it in the most intense forms of corneal inflammation. The portions of the cornea stained retain the color from half an hour to several hours. The solution produces not the slightest impression upon the healthy cornea. He always found, that when positive defects in the corneal epithelium existed—in other words, where there was actual loss of substance—the coloration was more apparent. So long, then, as it is possible to color any portion of the cornea, we may be certain that some lesion still exists. In excoriations of the cornea positive results were the rule. In ulcers of the cornea positive results were always obtained and in simple superficial keratitis the coloration was much less distinct than when this disease was associated with an ulcer. In parenchymatous keratitis the results were invariably negative. In foreign bodies in the cornea, no matter how small the foreign substance was, its position and size were located to a nicety. Here the coloration was immediate and distinct, showing itself by a green ring just around the foreign body. He thinks that when one is accustomed to the use of the solution—in other words, understands that where the coloration is produced the anterior epithelium is involved—the agent is of value in detecting, with accuracy, lesions of this part of the cornea. Ulcers so small that it is impossible to see them by diffuse daylight are brought out with perfect distinctness, quite as clearly indeed as under oblique illumination, and small points, which it is possible to overlook even with the oblique illumination, are invariably revealed by a drop of the solution; and, moreover, in half the time that it takes us to subject a patient to the former method. In minute ulcers of the cornea in very young children, where the blepharospasm and photophobia are frequently so intense that the lids have to be forced apart in order to get a view of the eyeball, and then the latter is rolled about so continuously, and the cornea flits so rapidly before our eyes that we are obliged simply to infer from the attendant symptoms the nature of the trouble without actually seeing the lesion itself, a drop of the solution will locate the disease and its extent, and bring it out distinctly so that it can be seen, no matter how fast the eyeball moves about.

Test for the Purity of Woollen Garments.—According to the *Sanitarian*, the genuineness of woollen clothing may be tested by placing a small fragment in caustic soda, which quickly destroys animal fibres, but has no effect upon those of vegetable origin. If the article is all wool it will be completely dissolved; if it has a groundwork of cotton the latter will remain.

THE MEDICAL NEWS.

A WEEKLY JOURNAL OF MEDICAL SCIENCE.

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1004 WALNUT STREET,
PHILADELPHIA.

Subscription Price, including Postage.

PER ANNUM, IN ADVANCE \$4.00.
SINGLE COPIES 10 CENTS.

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SATURDAY, MAY 3, 1890.

THE REVISION OF THE PHARMACOPŒIA.

ON the 7th of next month the Convention for the Revision of the United States Pharmacopœia will be convened in Washington, and, while we have already called the attention of the profession to the importance of a full delegation of medical men being present, we wish to reiterate the facts which have been already presented, and to offer additional reasons why everyone should go who has received the proper qualifications.

In the first place, the United States Pharmacopœia when arising from the intellect of but a few persons coming from a very limited territory, many of them having peculiar ideas, can in no way represent the opinion of the professions of medicine and pharmacy throughout the United States. Anyone who will glance at the Pharmacopœia of 1880 will notice that it contains some drugs which are exceedingly local in their use, and which perhaps are not employed anywhere out of the county, or at least the State, in which they are grown. It will also be found that remedies which have a much wider use do not appear; and more than all, that the measures for the manufacture of many of the pharmaceutical preparations are impracticable in the hands of the ordinary pharmacist.

We have also called attention to the immense variation which occurs in the strengths of tinctures

and fluid extracts, and we have but recently seen a case in which belladonna was given, obtained from one store, without any effect, while that obtained from another store was too powerful in its influence, and occasioned decidedly unfavorable symptoms. It is evident that if the practice of medicine and pharmacy is to be based on scientific ground, better directions than the use of so many ounces or parts of a crude drug and so many parts of alcohol must be resorted to; since plants of the same species, growing under different circumstances in regard to heat, moisture, and soil vary, as everyone knows, very considerably in their external appearance, but even more so in the quantity of their active principles.

Unfortunately for the cause of standardization of drugs, a number of the members of the medical and pharmaceutical professions have obtained the idea that the movement is for the benefit of a well-known firm of manufacturers of medicines, and that this measure is calculated to be solely beneficial, from a commercial standpoint, to the members of this firm. Nothing can be more unjust or absurd, since the opponents of standardization virtually acknowledge by this outcry that their preparations are not standardized, for if they were, no objection would be made on their part to the movement. By the bitter opposition which some journals exhibit, the fable of the dog and the bone is exemplified; for, in their endeavor to prevent standardization by denouncing the only firm using standard methods, they give their opponents an advertisement and indorsement than which nothing could be further from their wishes, and which has already caused a number of physicians in this city to order only those drugs made by the one firm in dispute. We cannot help feeling, however, that the adoption of the term used at present by any single house to designate standardized drugs is entirely out of place, and we think that the word "standard" or "assayed" is the word to be employed.

CHRONIC PLEURISY AND EMPYEMA.

INFLAMMATION of the pleura is an important subject, both by reason of its frequency and of the serious complications, or sequelæ, that may attend it. That "busy practitioner," for whom so much compressed and sugar-coated literature is nowadays manufactured, is too apt to pass by unread, contributions on so old and familiar a theme, unless, perchance, his eye be taken by the formula of a never-

failing prescription. Yet, as LIEBERMEISTER, in his recent valuable series of articles (*Deutsche medicinische Wochenschrift*, 1890, Nos. 10, 11, 12, 13), observes, "physicians whose resort to percussion is infrequent, may for many weeks together treat a patient for gastric catarrh, while in reality he suffers with an extensive pleural effusion;" for the symptoms of chronic pleuritis are indefinite and often misleading. Fever is slight, or, indeed, absent. Cough may be wanting. The phenomena, and especially those of pain and discomfort, due to pressure upon, and displacement of, neighboring organs by the distended pleural sac, are open to complete misinterpretation. Only by careful physical examination is the true nature of the case made evident; nor are the results of physical examination, while usually conclusive, absolutely beyond possibility of mistake in all cases. The diagnosis, then, is not a matter of such plain sailing that everyone may assume to know perfectly all the ins and outs of the channel, so soon as he has received his pilot's certificate. In those cases where the intrapleural effusion persists or recurs after subsidence of the more prominent symptoms of an acute attack, mistake is less likely to occur than in the not uncommon cases where the affection is, from the outset, sluggish and ill-defined. The patient, in this latter class of cases, most frequently comes under observation late in the progress of the disease, and has no history of acute distress in the thorax to direct attention to that region. In our own dispensary experience, moreover, even when cough and dyspnoea are so marked in cases of chronic pleurisy that superficial examination of the chest cannot be omitted, it is not rare to find that such diagnoses as asthma and consumption have been made. Especially is the case liable to be mistaken for pulmonary tuberculosis, when the effusion is purulent and irregular chills and fever form part of the clinical picture. Hydrothorax from passive transudation, as in cardiac and renal disease, may sometimes be difficult to discriminate from effusion the result of chronic inflammation of the pleura. In the former, however, the effusion more readily shifts its place with change of body-posture, being thinner and unhindered by adhesions. Hence, too, the line of the upper level of dulness is horizontal, while the corresponding line in cases of pleuritic effusion is more usually curved. Further, hydrothorax is almost invariably bilateral, while pleurisy is more frequently unilateral. Hydrothorax is rarely the only manifestation of a systemic process, but is

associated with ascites or general anasarca. Nevertheless, as Liebermeister points out, the two conditions may coexist as complications, or there may be transition from one to the other. For example, effusion due to neoplasm may be called chronic pleurisy with as much propriety as inflammatory hydrops. Or if, after the disappearance of a general hydrops, some obstinate residue be left in the pleural cavity, it may be considered as certain that we have been dealing not merely with a simple transudation, but with an inflammatory process as well. If the fluid be drawn off, it may be considered non-inflammatory when it contains no fibrin, is of low specific gravity (1014 or less), and is feebly albuminous ($2\frac{1}{2}$ per cent. or less of albumin). If, however, it contains 4 per cent. or more of albumin, or the specific gravity reaches 1018, it is of inflammatory origin.

Empyema may follow acute or chronic pleurisy with sero-fibrinous exudation, in which a constantly increasing number of round cells is developed, gradually converting the whole into a purulent exudation. In particular, this result may quickly follow when through any means—for example, a paracentesis not made aseptically, or during the performance of which, air is allowed to enter the chest—pyogenic microbes are introduced. Suppuration often occurs, however, without ascertainable extraneous infection, and in many cases the pleuritis assumes from the first a purulent form. The latter condition, according to Liebermeister, is by no means so uncommon as recent writers assert. It occurs in traumatic disease, when the thorax is penetrated and air or foreign bodies enter the pleural sac; in inflammation following suppurative processes in neighboring structures, whether through perforation or extension by continuity of tissue; in the pleuritis of pyæmia or puerperal fever, whether as a sequel to metastatic abscesses in the lung or without the development of such abscesses; in variola and scarlatina, and, less often, in other similar infections. Finally, in the form which accompanies pneumonia, the exudation is so frequently purulent from the first, that ground is given for the opinion that the same microbe which excites the pulmonary inflammation is the direct cause of the accompanying pleurisy. In children, as is a matter of everyday observation, purulent pleural exudations are more common than in older persons.

Concerning physical diagnosis, Liebermeister can give us no means of discriminating between

purulent and non-purulent effusions. Auscultatory signs, he believes, depend less on the qualities of the exudate than upon the condition of the bronchioles in the compressed lung. This accords with our own experience. In the absence of external evidence of abscess, or the formation of a fistula, the hectic fever, emaciation, and rational signs of suppuration suggest the diagnosis, and finally exploratory puncture confirms it. When the presence of purulent effusion is not detected, and the collection of pus is allowed to remain undisturbed in the pleural cavity, the consequences are serious, and, in the majority of cases, fatal. Penetration of pus into a bronchus with evacuation by cough, is said to be the least unfavorable route for spontaneous discharge. Penetration externally, with formation of subcutaneous abscess, however (*Empyema necessitatis*), is by no means an unmixed evil, for it has, in instances which have come under our own observation, led to incision of the fluctuating swelling in the back or side, and thus to the recognition and proper treatment of the previously unrecognized condition. Nevertheless, the practitioner who is not too busy to examine his patients, will not willingly trust the unassisted efforts of nature to secure evacuation of the pus, but will proceed to remove it as soon as he has made himself aware of its presence.

The questions as to the best method of operation, whether by puncture or free incision, and the details of the procedure; as well as those bearing upon the indications for removal of non-purulent effusions, demand consideration in another article.

LIKENESS AND UNLIKENESS.

THE shades of resemblance between the denizens of the various natural kingdoms are infinite, and it is this pleasing variety which stimulates the devotee of science to new research and prevents his work from being rendered stale by custom. It is this, also, which, in common with the "personal equation," leads to the greatest differences of opinion in every field of research and more particularly if the field is microscopic.

A recent number of THE MEDICAL NEWS contained an editorial on the effect of heat upon the red blood-corpuscles, and warned against the possible mistake of confounding the changes thus induced with those caused by the hæmatozoon malarie. The article elicited a reply from a learned and distinguished confrère, who states that these effects of heat are

well known to the expert, and are not likely to be misunderstood by anyone not a tyro.

When, however, it is recalled, first, that the number of experts in such matters is very small; secondly, that it took them a long time to confirm the observations of Laveran, and, thirdly, that one of the best known among them at first pronounced the malarial changes in the red corpuscles to be nothing more than vacuoles, it becomes evident that our warning, which was given for the benefit of all, and not for the few, was well timed.

REVIEWS.

A TREATISE ON MATERIA MEDICA, PHARMACOLOGY, AND THERAPEUTICS. By JOHN V. SHOEMAKER, A.M., M.D., and JOHN AULDE, M.D. 8vo., pp. 353. Philadelphia and London: F. A. Davis, 1889.

THE authors of this treatise have evidently struggled for originality, with a result which, to say the least, is somewhat peculiar. Their classification of drugs is exceedingly confusing, and in some instances misleading. For example, "alkaline or antacid medicines" are divided into (1) "direct alkaline remedies," including solution of potash and bicarbonate of sodium; (2) "direct, but not remote," including solution of ammonia, and, for some inexplicable reason, charcoal; and (3) "remote alkaline remedies," including salts of potassium and sodium with a vegetable base. Alum, sulphate of iron, perchloride of iron, oxide of zinc, oil of turpentine, creasote, and carbolic acid are placed in a list of the mineral acids, an innovation which we think demands an explanation. Digitalis is considered as a vascular sedative and grouped with aconite, hydrocyanic acid, tobacco, etc. On the next page we find a list of so-called "vascular tonics" (not vascular stimulants, which are elsewhere considered, with no mention of digitalis), among them acids, astringents, alcohol, iron preparations, ammonia, and digitalis *again*. Such a system, or rather want of system, cannot be other than confusing and discouraging to medical students.

Inaccurate statements show that the book has been either hastily or carelessly prepared. For instance, in discussing asthma it is stated that "Dr. Bosworth gives a tabulated account of eighty cases treated mainly by the insufflation of cocaine, and with marked success." Bosworth's eighty cases were *not* treated mainly by cocaine, but by cauterization, septum operations, removal of polypi, adenoid growths, etc. The authors probably had in mind a previous paper of Bosworth in which he said that intra-nasal applications of cocaine *relieved* the asthmatic paroxysms.

Another unfortunate feature of the treatise is the frequency with which the authors state their own beliefs dogmatically as facts, without qualification or supporting evidence.

The most useful sections are those upon alimentation and electricity, which are fairly complete and instructive. There are also interesting descriptions of hypnotism,

earth dressings, climatology, and several other therapeutic agents not usually considered in text-books.

The book could have been greatly improved by judicious pruning, by closer attention to the rules of composition, which are sadly neglected, and by the avoidance of unnecessary digressions; and it is to be hoped that the authors will make these changes should the volume ever reach a second edition.

A TEXT-BOOK OF HUMAN ANATOMY: SYSTEMATIC AND TOPOGRAPHICAL, INCLUDING THE EMBRYOLOGY, HISTOLOGY, AND MORPHOLOGY OF MAN, WITH SPECIAL REFERENCE TO THE REQUIREMENTS OF PRACTICAL SURGERY AND MEDICINE. By ALEXANDER MACALISTER, M.A., M.D., F.R.S., F.S.A. Philadelphia: P. Blakiston, Son & Co., 1889.

THIS is, in many respects, a remarkable book, comprising as it does the outcome of modern scientific methods as applied to human anatomy. To the student interested in morphology and embryology it will be most valuable, as it embraces in all their essential details the facts pertaining to these departments of study in their relation to the various regions of the body considered topographically.

The thoroughness and perspicuity with which the whole subject is treated are impressed upon every page, and testify to the well-earned reputation of the author.

As a book of reference for the advanced student or practitioner, it will prove very useful; but to the beginner or ordinary student of medicine, it cannot be recommended as a text-book.

The endeavor to conform to the exact technicality of modern scientific expression and the substitution of new descriptive terms for older and less accurate ones, while it may be a satisfaction to the mind of the author, will not render the difficult study of anatomy any easier, unless it has been preceded by a more careful scientific training than most of our colleges afford.

The ordinary names of parts and distinctive terms, which long usage have rendered characteristic, are hard enough to comprehend and acquire, but have, by their very individuality, a power of arresting the attention of the learner, besides possessing the historic value to which Professor Macalister refers.

We would especially call attention to the chapter on *cranio-cerebral topography*, where, besides referring to the divergence of the angle between the Rolando-auricular and ecto-cantho-Rolandian lines, and similar typical expressions for determining the relations of brain surface and bone surface, the author makes the really important statements that "the relations of the convolutions to the surface markings are variable within many wide limits," and "that all systems of definite measurements must be taken with limitations." This is, well worthy the emphasis put upon it, in refutation of the assertions not uncommonly met with in the medical writings of the day, by which the uninitiated would be induced to believe that any clever surgeon can put his finger over the exact spot where a cerebral lesion exists.

The illustrations are numerous, and—with the exceptions of those showing the bones and muscles—well chosen. The original diagrams are excellent.

SOCIETY PROCEEDINGS.

NEW YORK ACADEMY OF MEDICINE.

Section on Pædiatrics.

Stated Meeting, April 10, 1890.

L. EMMETT HOLT, M.D., IN THE CHAIR.

DR. F. M. CRANDALL presented a urethral calculus which he had removed from a child three years old. Although the child had passed very little urine for seventy-two hours previous to the removal of the obstruction, the chief symptom for which the mother had sought advice was a continuous forcing down of the rectum. The calculus was situated one-fourth of an inch from the meatus.

DR. I. H. HANCE presented a renal calculus which had been removed post-mortem from a baby of twenty months, who had presented no symptoms of such trouble. There were no signs of pyelitis found. The question arose as to whether it was congenital, which the size of the stone seemed to indicate.

The Chairman reported two cases of

ACUTE PRIMARY PNEUMONIA IN INFANTS, WITHOUT FEVER.

In neither case were any of the usual symptoms of pneumonia present, and yet the post-mortem examination, both macroscopical and microscopical, showed the characteristic lesions of pneumonia.

DR. A. JACOBI said that the description of the microscopical appearances in these cases indicated that the pneumonia was not a secondary process. Pneumonia, with but little rise of temperature, was noticed in very young and in very old subjects, in young infants whose vitality had been impaired by previous disease, and in the cases with brain symptoms at the beginning of the disease.

The discussion on

THE USE OF SPIRITS AND MALTED DRINKS IN NURSING WOMEN

was opened by Dr. A. Jacobi. He said that a proper understanding of the subject necessitates a consideration of the nature of the mammary secretion, and the circumstances under which it might become mixed with drugs or other substances found in the circulation. It is well known that various substances of this nature have been found at times in human milk; but the results of such observations have often been conflicting. These discrepancies, however, can be reconciled by an application of our knowledge of the physiology of lactation. Milk, so far as its chief solid ingredients are concerned, consists of the transformed cells of the mammary glands. It contains a considerable quantity of potassium, phosphate of lime, a very little chloride of sodium with casein, milk sugar, and more fat than is found in the blood. If the change in the mammary epithelium is incomplete, the resulting secretion is not milk, but colostrum; and the condition of the gland itself influences the quality of the milk much more than any single article of diet. But the general health, emotional condition, and the period of lactation all profoundly influence the quality of the secretion, and may, by causing its deterioration, lead to an ad-

mixture of the milk with transuded blood serum. This "transudation milk" often contains medicinal substances found in the circulation; and hence, a dose of opium which in the later months of lactation would have no effect upon the child, might, if administered immediately after confinement, while the colostrum is still being secreted, exert a dangerous influence upon the nursling. A similar state is induced by sudden and violent emotions. Applying this knowledge to the topic under discussion, it is seen that while the mammary secretion is of proper quality, alcohol might be taken without affecting the child in any way; but a deterioration of the milk might be accompanied in some cases by unpleasant symptoms referable to the alcohol which had been taken by the nurse. The literature of this subject is very scanty, and many of the modern observations lack scientific precision. In 1853 Becquerel announced as the result of a series of observations, that children of nurses who took alcohol freely exhibited somnolence, restlessness, and occasionally convulsions. Stumpf concluded, as the result of his researches, that the quantity of milk was not influenced by the presence of alcohol, and he added that he knew of only one remedy which would increase its quantity, and that was salicylate of sodium. This is in accordance with Dr. Jacobi's own experience with the effect of salicylate of sodium upon other secretions, notably that of the liver. He considers it the most reliable remedy in our possession for preventing the formation of gall-stones. He thought the use of alcohol by nursing women should be forbidden, except where there is a definite indication for its use as a medicine. Ordinarily, women require about 90 grammes of albumin daily, but when nursing, this amount increases to about 150 grammes; and the additional quantity is to be supplied by a liberal diet of meat and milk.

DR. E. L. PARTRIDGE was of the opinion that the quantity of milk could be decidedly increased by the use of malted drinks; and he thought this was brought about partly by the larger quantity of fluid ingested, and partly by its beneficial effect upon the maternal nutrition. He did not, however, approve of this "high-pressure nursing" any more than he approved of a broker sustaining his strength, amid excitement, by the use of tobacco and alcohol. Such nursing is likely to bring on functional disorders of the heart and pelvic organs, and it is entirely unnecessary in these days of improved artificial infant foods. Many women with deficient milk are improved by anything which they firmly believe is capable of rendering the desired assistance; and this knowledge can often be turned to good account to tide a nervous, apprehensive patient over a critical period. It is on this principle that he explained the good effect which he had observed to follow the use of a much-vaunted preparation. He believed its therapeutic virtues were to be found in the positive assurances of its efficacy, as stated on the label. There is no good reason for depriving those long accustomed to the use of malted drinks of their accustomed beverage, and there is no advantage in beginning the use of alcoholic drinks during lactation, except for medicinal purposes.

DR. A. SEIBERT said that in the discussion, so far, the rôle played by the bacteria found in alcoholic beverages had been entirely ignored. Many of the poorer classes drink large quantities of stale beer, which he had often

seen affect the child very unpleasantly. It was his custom, therefore, whenever a child was taken sick with a gastro-intestinal disorder, to forbid the use of beer by the mother.

DR. E. H. GRANDIN has always been in the habit of allowing malt liquors to such nursing women as seemed to need a stimulant; and although he has had excellent opportunities for observing the effects of beer-drinking, he has never been able to trace any injury to the child from the moderate use of such liquors. He thought that both the quantity and the quality of the milk had been improved by such treatment.

DR. JACOBI, in closing the discussion, remarked that there seemed to be a pretty general agreement upon the statement that liquors were unnecessary, and for the most part injurious when used by nursing women; although they might be required as medicinal agents to aid in some cases in the digestion of the large quantities of carbo-hydrates necessary for the proper nutrition of the nurse.

CORRESPONDENCE.

SHORT-WEIGHT QUININE CAPSULES.

To the Editor of THE MEDICAL NEWS,

SIR: My attention having been called to the very evident short weight of some quinine capsules in the market, I determined to investigate the matter. I had believed that the present low price of quinine had removed all incentive to the placing of short-weight capsules on the market, but my investigations have convinced me that such capsules are even now offered for sale. Whether their existence is due to intentional fraud or to gross carelessness I cannot say, but I feel that the attention of the medical profession should be called to the existence of such capsules. These capsules were bought in the market in Detroit in original packages. Each package consists of a tin box, on the uppermost surface of which is a yellow label bearing the following: "Keep in a cool, dry place. Superior gelatin elastic capsules. Prepared from extra French gelatin. The drugs are the best that can be procured. Manufactured by the Merz Capsule Company, Detroit, Mich." On the end of the box is a small white label, bearing the following:

"106.—Quinine sulph. . . . 3 grains.
Capsicum 1-3 grains."

I obtained four of these boxes, which I will designate by the numbers 1, 2, 3, and 4. In box No. 1 the capsules were not elastic, but were hard. This box contained originally 104 capsules. The short weight of these was easily determined. Twelve of the capsules, taken at random, weighed, gelatin and contents together, 1.858 grammes or 28.67 grains, or a little less than 2.4 grains each. There could be no doubt about short weight in these. The actual amount of quinine in each of 12 capsules was determined as follows: The contents of each capsule were placed in a weighed one-ounce Erlenmeyer flask. The gelatin was washed free from quinine with absolute alcohol, the alcohol added to the quinine in the flask, the alcohol evaporated at a low

temperature, and then the flask, with its contents, was dried at 105° C. to a constant weight. The weight of the anhydrous quinine sulphate multiplied by the factor 1.193 gives the weight of crystallized sulphate, allowing 8 molecules of water of crystallization, the highest amount of water allowed by the U. S. Pharmacopœia. The following table will show the result of these determinations:

No. of capsule	Weight of flask.	Weight of flask and anhydrous quinine sulphate.	Weight of anhydrous quinine sulphate.	Weight of crystallized quinine sulphate.	Weight of crystallized quinine sulphate
	Grammes.	Grammes.	Milligram.	Milligram.	Grains.
1	16.616	16.664	48	57.3	0.88
2	15.310	15.355	45	53.7	0.83
3	13.162	13.200	38	45.3	0.70
4	16.350	16.395	45	53.7	0.83
5	14.405	14.458	53	63.2	0.98
6	11.525	11.567	42	50.0	0.77
7	13.193	13.250	57	68.0	1.05
8	17.408	17.445	37	44.0	0.68
9	12.247	12.299	52	62.0	0.96
10	14.901	14.945	44	52.4	0.81
11	12.248	12.297	49	58.4	0.90
12	13.540	13.594	54	64.4	0.99

It will be seen from the above figures that the average amount of quinine is less than one-third of that which the capsules are advertised as containing. So much for the quinine; how about the capsicum? The contents of several capsules were dissolved in water with the aid of dilute sulphuric acid, and *not the smallest trace of capsicum could be found.*

In box No. 2 the amount of quinine was found to be larger than in the capsules from box No. 1, but again no capsicum could be detected. The method of determining the amount of quinine was the same as given above, and in order to save space I will only report results:

Capsule No.	I contained . . .	2.28 grains.
" 2 "	" . . .	2.23 "
" 3 "	" . . .	2.28 "
" 4 "	" . . .	1.85 "
" 5 "	" . . .	2.48 "
" 6 "	" . . .	1.46 "
" 7 "	" . . .	2.03 "
" 8 "	" . . .	1.69 "
" 9 "	" . . .	2.47 "
" 10 "	" . . .	1.54 "
" 11 "	" . . .	1.50 "
" 12 "	" . . .	1.22 "

The capsules in boxes Nos. 3 and 4 contained capsicum, and the amount of quinine sulphate was determined as follows: Each capsule was placed in a clean one-ounce Erlenmeyer flask, 5 c.c. of distilled water, and 2 drops of dilute (1:5) sulphuric acid added. The flasks were then kept at 38° C. until the capsules had dissolved. The acid solution was then shaken with ether, and after separation the ether was removed and discarded. The contents of the flask were now rendered alkaline with a ten per cent. solution of sodium hydrate, and extracted twice with 25 c.c. of absolute ether. The ether was placed in weighed Erlenmeyer flasks and kept at 30° C. until the ether had evaporated, then heated at 105° C to a constant weight. The weight of the anhydrous quinine multiplied by the factor 1.3734 gives the weight of

crystallized sulphate of quinine with 8 molecules of water of crystallization $(C_{20}H_{24}N_2O_3)_2 \cdot H_2SO_4 \cdot 8H_2O$.

Twelve capsules taken at random from box No. 3 contained the following amounts of crystallized sulphate of quinine:

Capsule No.	I contained . . .	2.62 grains.
" 2 "	" . . .	2.54 "
" 3 "	" . . .	3.01 "
" 4 "	" . . .	2.96 "
" 5 "	" . . .	2.43 "
" 6 "	" . . .	2.22 "
" 7 "	" . . .	1.93 "
" 8 "	" . . .	2.78 "
" 9 "	" . . .	2.39 "
" 10 "	" . . .	1.99 "
" 11 "	" . . .	1.95 "
" 12 "	" . . .	2.30 "

Twelve capsules taken at random from box No. 4 contained the following amounts of crystallized sulphate of quinine:

Capsule No.	I contained . . .	2.62 grains.
" 2 "	" . . .	2.57 "
" 3 "	" . . .	2.53 "
" 4 "	" . . .	2.17 "
" 5 "	" . . .	2.86 "
" 6 "	" . . .	1.65 "
" 7 "	" . . .	2.16 "
" 8 "	" . . .	3.01 "
" 9 "	" . . .	2.86 "
" 10 "	" . . .	1.76 "
" 11 "	" . . .	1.74 "
" 12 "	" . . .	1.63 "

It will be seen that, out of 48 capsules assayed, only 2 contained the amount of quinine claimed on the label.

Respectfully, V. C. VAUGHAN, M.D.

UNIVERSITY OF MICHIGAN, ANN ARBOR.

THE EFFRONTERY OF PROPRIETARY MEDICINE ADVERTISERS.

To the Editor of THE MEDICAL NEWS,

SIR: Two notable instances of the unscrupulous methods of pushing proprietary medicines have lately presented themselves which should be held up as a warning to those who permit their names to be used by advertisers.

A few weeks ago I received a folded card, which was widely distributed to the profession, on the outside of which was printed, in large capitals, "BELLEVUE HOSPITAL MEDICAL COLLEGE." This appeared like an official issue by the College. It contained the following: "The expressions of the Medical Profession regarding the efficacy of 'Vin Mariani' in therapeutics can be summarized as follows:

"As a tonic in laryngeal and gastric complications; as a diffusible stimulant in anæmia, nervous depression, melancholia, tardy convalescence, general 'malaise,' and in all those cases in which there is much depression and atony.

"Topically in convulsive cough, laryngitis, stomatitis, etc.

"We refer by kind permission to the following physicians, members of the Alumni of Bellevue Hospital College."

Then follow the names of 142 physicians residing in

different cities. Like circulars were distributed with the headings, "Jefferson Medical College" and the "University of Pennsylvania," and I am told that the names of other reputable colleges have been used in the same way. However these signatures may have been obtained, I venture to say that no one of the signers imagined that his name would be used in a broadcast advertisement, apparently issued with the approval of the college from which he had been graduated. This advertisement should teach the profession a lesson of the danger of giving testimonials under any circumstances. In the first place, no reputable physician makes use of testimonials, this method of advertising being confined to charlatans. In the second place, few if any can testify, from their own knowledge, to the truth of statements with regard to proprietary medicines. I think, also, that the profession does not now regard it as safe to put in the hands of patients, for use according to their own judgment, preparations containing cocaine. As a matter of fact, the enterprise shown by the Mariani Company will probably prevent those whose names have been used from prescribing the "wine," and will have a like influence on the alumni of the colleges the names of which have been used.

The other instance of effrontery in advertising is in the case of the "Lactopeptine Medical Annual" sent as an advertisement by the "New York Pharmacal Association." In this remarkable publication are process-reproductions of photographs of some of the professors in the Bellevue Hospital Medical College. The New York Homeopathic Medical College, the Medical Department of the University of Pennsylvania, the American Medical College (Eclectic) of St. Louis, and the College of Physicians and Surgeons, of Chicago, are treated in the same way. These colleges are therefore presented as giving countenance to the "Lactopeptine" remedies.

The publication of my portrait in the "Lactopeptine Medical Annual" is my excuse for a notice of the claims for "Lactopeptine" as a therapeutic agent. It is advertised that "Lactopeptine contains the five active agents of digestion—pepsin, ptyalin, pancreatin, lactic acid, and hydrochloric acid—combined in the same proportion as they exist in the human system. These digestive agents comprise all known substances employed by nature in the preparation of food for assimilation."

Let it be assumed that the pepsin has been extracted from pigs' stomachs by the best methods, and even that the ptyalin is pure, which is very improbable. According to the best authorities, ptyalin acts only in a neutral, or an alkaline medium. It is destroyed by hydrochloric acid, or by digestion with pepsin. Lactopeptine contains hydrochloric acid, or, if the pepsin be active, the influence of ptyalin must be *nil*. There is no such substance as pancreatin. The digestive constituents of the pancreatic juice are amylopsin, trypsin, strapsin, and a milk-curdling ferment. It is difficult to imagine that all these are contained in lactopeptine. Amylopsin is supposed to be identical with ptyalin, and all conditions which affect the action of ptyalin have a similar influence on amylopsin. The protolytic action of trypsin takes place in an alkaline medium only, and never in the presence of acids. An artificial digestive agent containing hydrochloric and lactic acids and trypsin is an impossibility, so far as any action of trypsin is concerned.

Strapsin is a very unstable substance, and nothing need be said with regard to its possible action or the action of a milk-curdling ferment, as these substances exist, if they do exist, in such a compound as lactopeptine purports to be.

Lactopeptine, so called, as an aid to digestion, is a physiological absurdity. Anyone who prescribes it in digestive disturbances, does so in opposition to universally accepted facts in physiology and sound therapeutic principles.

AUSTIN FLINT, M.D.

VIENNA.

To the Editor of THE MEDICAL NEWS,

SIR: There have been some changes in the medical faculty here that are worthy of mention. The famous physiologist, Professor Brücke, now more than seventy years old, has become tired of the strain of a professorship and has resigned. The faculty thus lose one of their brightest lights, for his name stands high in the annals of physiology. The faculty have selected Professor Exner, now extraordinary professor of histology, as his successor—subject to royal approval. Dr. Bueczasy, whom many Americans remember as Schnitzler's first assistant in laryngology, and who was one of our favorite teachers, has also resigned; it is said that he may conduct private courses on throat and nose later in the season.

At present there are two University clinics in internal medicine—Nothnagel's and Kahler's, and Parliament has decided to erect a third, with Schrötter as Professor and director. For the two surgical clinics—Billroth's and Albut's—more room is to be given in the spring.

One of the most interesting clinics here is Neuman's on skin and syphilis. He shows about six cases a day, has them stripped entirely naked, and standing on an elevated platform before the class. He shows men and women on alternate days, and gives excellent demonstrations, paying special attention to the genitals, and giving most of the men present a chance to examine each case. Neuman is very witty, and constantly joking with his patients. Partly because he is such an excellent teacher, and partly because he is popular, his courses are very well attended.

Professor Monti gives one of the best courses in Vienna on diseases of children. Though he speaks miserable German, he gives points of great practical value, shows very interesting cases, and demonstrates them in such a manner that children's diseases become a fascinating study. He states that of the 6000 cases annually treated in his clinic four-fifths are rachitic, and as he has thoroughly tried the phosphorus treatment without satisfactory results, he condemns it. Hygienic treatment, with abundant fresh air, is the only means that he employs for relieving the disease. In croup he gives salicylate of sodium, quinine, or morphine *pro re nata*, but insists that shortening of the disease or a cure has never taken place. Last week he showed us a case of congenital pemphigus. The child was three months old and was literally covered with vesicles, the back being one huge blister, the heels and palms denuded of epithelium by the breaking of the vesicles, and the patient presented a horrible spectacle. It had pneumonia in addition, and showed all the signs of chronic dyspepsia.

Professor Reuss has a new method of treating kera-

titis, based on the following reasoning: Atropine and all mydriatics contract the iris and increase intra-ocular pressure. Eserine and myotics lessen the intra-ocular tension. In keratitis if we can increase the blood-supply to the inflamed spot in the cornea we shorten the process and prevent its spreading; and by reducing intra-ocular tension we open the spaces between corneal layers and allow blood to circulate more freely. Hence in simple keratitis he always uses myotics. When, however, perforation threatens and iritis is a complication, he asks: Will synechiæ do more harm as regards the usefulness of the eye, in that particular case, than large *maculae corneæ*, and on the answer bases his treatment. If the *macula* be in the centre, and a subsequent iridectomy gives better chances for good vision, he continues eserine, caring nothing about synechiæ; but if the *macula* be near the limbus, preservation of a good pupil becomes the leading indication, and atropine must be used. As an antiseptic for the corneal wounds, and when the inflammation has disappeared, he uses calomel or iodoform.

The Paris *Journal de Médecine* accuses Pasteur of issuing incorrect reports upon his work in hydrophobia. It states that he reports but eleven deaths, while the records show twenty-six, and that taking the real ratio of deaths to cases treated his results are no better than those of ordinary treatment. Dr. Rascol, of Murat, even accuses Pasteur of introducing the disease and directly causing the death of one of his patients. Two men had been bitten by the same dog at the same time. The more severely injured man was treated at home, was not inoculated, and recovered; the other was sent to Pasteur, and soon died of hydrophobia after the inoculation treatment. We hear nothing about Pasteur here now—a suggestive silence.

The Americans here have had many a laugh about the telegraphic reports in American papers, especially in the *New York Herald*, concerning the influenza bacillus. It is now settled that no new bacterium was discovered as a cause of influenza. There is no Professor Jollies in Vienna, so the wide-awake reporter was slightly mistaken, or perhaps the victim of a practical joke, and his whole story, as the *Herald* told it, was simply a newspaper canard.

It is another proof of how little reliance can be placed on telegraphic reports concerning scientific work.

There have been a number of rare and interesting cases here lately. A few days ago Albert operated for the removal of an ovarian tumor; there were all the physical signs of ovarian cyst, yet when it came to ligating the pedicle it was discovered that the growth was a true uterine cyst, not resulting from partial central necrosis of a fibroma. There are but few similar cases on record. Dr. Hochenegg, Albut's first assistant, also showed us a peculiar case. An old woman, whose son had died of tubercular caries, had nursed him during his illness and had scratched her finger on a spicula of diseased bone. This was two years ago, and now her index finger, the one then injured, shows a typical tuberculous ulcer. Along the dorsum of the hand and forearm there is a well-marked chain of hard lymphatics, the ducts are evident to touch, like strings, while the glands feel hard and as large as cherry-stones. It is strange that but one chain of lymphatics exists, and

that in this case they should be so hard from tuberculosis, when generally tubercular infiltration causes degeneration. The etiology is so clear that an operation removing the finger and extirpating all the glands is advised.

Hochenegg has introduced a new operation into gynecology for removal of the uterus in severe cases of cancer. It is a modification of Kraske's operation for removal of the rectum from behind. He makes a crescentic cut with the convexity upward, from the left sacroiliac synchondrosis to one inch to the right of the end of the coccyx. Cutting down to the bone and dissecting back the coccyx, about one inch of the latter is chiselled off. This gives a free opening for working on the rectum—so far Kraske's method. Now, Hochenegg goes in between the rectum and cellular tissue, pushing the former to one side, and thus reaching the uterus, which can, with the infiltrated tissues around, be easily extirpated. The great advantage is plenty of light and room for working, the ease with which hæmorrhage can be controlled and all the diseased parts can be seen and removed. Of course, the severity of the operation makes it advisable only when the neoplasm is so large and the infiltration so great that colporo-hysterectomy or laparotomy would not give sufficient room to remove the whole mass. He has operated in eight cases, in all of which operations were declared impossible by the gynecologists here, and has had seven recoveries; certainly a brilliant result.

Professor Rydygier, of Krakau, has a new treatment for uterine fibroids, when the patients refuse to submit to oöphorectomy or excision of the tumor. He simply ties all the arteries entering the growth—of course, after laparotomy—and reports good results in several cases.

We had an interesting case in Nothnagel's wards last week. An old woman who had had a scirrhus of the breast removed ten years before, was perfectly well until several months ago. Since then she has gradually grown weaker, has noticed that she could not walk in the dark or with closed eyes, and that her legs were becoming numb and too feeble to carry her weight. In her legs sensation is perfect, the patellar reflex almost absent, muscular sense good; but voluntary motion markedly feeble. In her arms the reflexes are increased, motor power somewhat diminished, and muscular sense almost gone, so that when she closes her eyes motions with the arms are markedly ataxic. The eye reflexes are all present; there is slight facial paresis on the left side. She has excruciating pains in the spinal column. There is considerable cachexia, and on her back we found a number of hard nodules, which examination showed to be metastatic carcinomata. In the left axilla there is a bunch of hard infiltrated glands, and even in her lower limbs a few nodules exist. No known nervous disease will explain the symptoms of the case, so metastatic carcinomatous nodules in the spinal cord become a probable diagnosis. There are but very few such cases on record, and the excruciating pains in the column were present in all.

On the 14th of April the European Congress for Internal Medicine meets in Vienna, and a large attendance is anticipated, for many of Germany's best clinicians have announced papers and accepted parts in the discussions. Nothnagel is President.

Another former assistant of Billroth has reached distinction. Dr. Mikulicz has been appointed successor to the famous Volkmann, at Halle. Other former assistants from this great Vienna clinic are Czerny, of Heidelberg, and Wölfler, of Graz.

NEW YORK.

First Annual Reunion of the Society of the Alumni of Bellevue Hospital.

To the Editor of THE MEDICAL NEWS,

SIR: This active and rapidly growing Society held its first annual reunion on April 8th, 9th, and 10th. The first session was in the evening, and was held in the Mott Memorial Hall. Dr. Charles Phelps presented a very thoughtful and earnest paper on "The Treatment of Simple Fracture of the Patella by Wiring," in which he spoke emphatically against what he considered the excessive conservatism which prevented the general acceptance of this method of treatment. The paper was based solely upon his own extensive experience with this operation. The paper was discussed by Drs. Abbe, Bryant, Dennis, Leale, L. A. Stimson, and Stephen Smith; all of whom acknowledged the excellence of the results obtained by Dr. Phelps; but they were about equally divided as regards the advisability of recommending it to the profession at large as the best method of treating this fracture.

On the morning of April 9th, the Society attended a clinic held by Dr. L. A. Sayre at Bellevue Hospital; and in the afternoon of the same day listened to a paper on "The Ultimate Results of Injuries of the Hip-joint," by Reuben A. Vance, M.D., of Cleveland, Ohio. The paper was discussed by Drs. L. W. Hubbard, R. H. Sayre, J. McG. Woodbury, and J. Ridlon; all of whom looked upon the cases described in the paper as cases of chronic hip-joint disease.

Papers by Drs. John Warren and Brandreth Symonds on "Transient Glycosuria," and "Delicate Tests for Sugar in the Urine," then followed.

These papers referred particularly to the bearing of this condition upon life insurance. There was a lengthy discussion, in which Drs. H. M. Biggs, A. Flint, G. B. Fowler, R. W. Greene, and W. H. Thomson participated. The weight of opinion was in favor of Fehling's test and the fermentation test as being the best for clinical guidance. Drs. Flint and Thomson considered more especially the physiology and pathology of this important but decidedly obscure subject of transitory glycosuria.

The exercises of the day were closed by a banquet held at the Hotel Brunswick, which was very largely attended. The President, Dr. Richard Kalish, delivered a short address, in which he related the circumstances connected with the founding of the Society, and then referred to its rapidly increasing membership, and its present prosperous condition.

Dr. William H. Draper responded to the toast "Old Bellevue," and referred to the days spent there as truly the happiest of his life. He spoke of the many great teachers there in his time, only two of whom, Drs. Barker and Sayre, were still living. He closed his remarks by bidding the Society drink in silence to the memory of "Those who died in the discharge of their duty." Rev. S. MacAr-

thur, D.D., responded to "The Parson." He spoke of the power and influence wielded by a well-rounded character, and of the importance of a good preliminary, as well as a complete professional education. He said that this country must soon have a true University, which would probably be located in New York City. Speaking of the personal characteristics of "the parson" and "the doctor," he urged that both should be more careful to bring into the sick-room a flood of sunlight rather than gloomy forebodings. Dr. A. L. Loomis, in responding to "Progressive Medicine," remarked that it was a very hackneyed subject; but he treated it nevertheless in a novel manner, pointing out, as evidences of this progress, the higher fees now obtained; our less frequent wrangling with the homœopaths, who, in consequence, were busily engaged in cutting each other's throats; the use of trained nurses; and the establishment of gynæcology as a separate and lucrative speciality. "The Law" was responded to by Frank Loomis; "The Patient" by Charles B. Alexander; "The Press" by Chester A. Lord. President H. H. Porter, in responding for "The Commissioners," said that he had always endeavored, although often in the face of great obstacles, to advance the best interests of Bellevue Hospital. "Bellevue Hospital in its Relation to Medical Education" drew forth from Dr. Austin Flint the fact that as long ago as 1807 Bellevue Hospital was mentioned, and that in March, 1848, the new amphitheatre was opened, and the first clinic held in it by Professor Van Buren. After the establishment of the Board of Commissioners of Charities and Correction in 1860, the progress of the hospital was much more rapid. Many successful and brilliant men had been graduated from that institution; but he did not favor the extensive preliminary education demanded by some, as he thought such a provision savored of old educational ideas which were not applicable to the present times. Dr. William M. Polk then drew a vivid picture of the old-time Bellevue nurses, and contrasted them with the educated and skilful ones of to-day. He thought that they might prove a very important factor in case of pestilence or war.

This interesting series of meetings ended with a clinic in Bellevue Hospital given by Professor W. T. Lusk. An exploratory laparotomy was performed; and then a demonstration was given of Mr. Tait's operation for ruptured perineum.

NEWS ITEMS.

Niagara University Commencement.—On April 15th the Medical Department of Niagara University graduated a class of fifteen. This school has a three years' graded course.

Legacy to the New York Post-graduate Medical School and Hospital.—Among the legacies of the late Hon. Daniel B. St. John, of Newburgh, N. Y., was one of ten thousand dollars to the above-named institution.

Prostatic Operations.—Dr. William T. Belfield, 612 Opera House Building, Chicago, Ill., U. S. A., solicits information concerning unpublished cases of operations upon the prostate, especially for the relief of the so-called hypertrophy of the organ.

A Study of Diabetic Urine.—The undersigned, who is desirous of making an original research of the constituents of the urine in diabetes mellitus, *especially of acetone* and its supposed relations to the *coma diabeticum*, would be under obligation to any physician who would let him have the urine of such patients.—G. METZLER, University of Pennsylvania, 36th and Woodland Avenue, Philadelphia.

The Philadelphia Polyclinic Hospital.—The Board of Trustees of the Polyclinic Hospital at their regular meeting on April 21st created an additional Chair of Gynecology, and elected W. H. Parish professor to that chair. W. H. Sudduth, M.D., D.D.S., was elected Professor of Pathology and Dentistry.

The Building Committee reported that contracts had been awarded for \$37,430, and that work on the portion of new building, Eighteenth and Lombard Streets, would be completed prior to June 1st; and that \$11,560 would be needed to finish the interior ready for occupancy in September. To meet this amount Mr. Theodore Kitchen, Mr. C. C. Roberts, John B. Roberts, M.D., and the Ladies' Aid Society started a subscription paper for \$250 each. A similar paper has been started for running expenses, and already fifteen names were down for \$150 each as an annual contribution.

To avoid the delay in waiting for money to be contributed, Mr. Charles B. Baeder offered to loan, without security, the amount necessary to push the new building on to completion without delay.

The Treasurer's report showed:

Cash on hand	\$4424
Invested funds	5680
R. J. L. testimonial free bed fund	3580
Due from State, last instalment	2500
	—\$15,184
Liabilities for new building	15,000
Maintenance	2000

The recent investigations of charitable institutions had stimulated the trustees to institute a most searching investigation into the minute details of the Polyclinic Hospital. The House Committee reported that it had weekly inspected every part of the present temporary building, and could not too highly commend the efficient services of the matron and the apothecary.

The Ladies' Aid Society had been most efficient during the past three months by untiring devotion to their work. A large amount of money is now in their treasury for the children's play-room, the children's ward, and the bed for cripples.

A very successful tea was given at the Hotel Stratford on the evening of April 21st for the benefit of the building fund.

Vital Statistics of New York City in 1889.—The annual report of the Health Department shows that there were 39,583 deaths in New York City in 1889. The population being taken at 1,571,000, the death-rate was 25.1 per 1000. There were only 37,527 births recorded; marriages 14,400. Of smallpox there were two cases, with one death. There were 1414 cases of typhoid fever reported, and 351 deaths; 8849 cases of scarlet fever, and 1163 deaths; 6489 cases of diphtheria, and 1734 deaths; 6443 cases of measles, and 452 deaths; 128

cases of cerebro-spinal meningitis, and 110 deaths. The number of vaccinations was 74,500. The summer corps of physicians visited 34,500 houses, and prescribed for 16,150 sick persons.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, FROM APRIL 22 TO APRIL 28, 1890.

By direction of the Secretary of War, ROBERT H. WHITE, *Major and Surgeon*, now on duty at Fort Myer, Virginia, will report in person to the Superintendent of the U. S. Military Academy, West Point, New York, for temporary duty as Post Surgeon during the absence of Henry McElderry, Major and Surgeon, as a member of the Army Medical Board, New York City. Upon the return of Major McElderry to duty at West Point, Major White will return to his proper station.—Par. 4, S. O. 94, *Headquarters of the Army, A. G. O.*, April 22, 1890.

By direction of the Secretary of War, the following changes of stations of officers of the Medical Department are ordered:

KILBOURNE, HENRY S., *Captain and Assistant Surgeon*.—From Vancouver Barracks, Washington, to Willet's Point, New York.

GRAY, WILLIAM W., *Captain and Assistant Surgeon*.—From Fort Maginnis, Montana, to Fort Sherman, Idaho.

BANISTER, JOHN M., *Captain and Assistant Surgeon*.—From Fort Sherman, Idaho, to Fort Stanton, New Mexico.—Par. 1, S. O. 93, *A. G. O.*, April 21, 1890.

RAYMOND, HENRY I., *Captain and Assistant Surgeon* (Newport Barracks, Kentucky).—Is hereby granted leave of absence for twenty-five days, to commence on or about May 2, 1890.—Par. 5, S. O. 91, *Division of the Atlantic*, April 19, 1890.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF THE MEDICAL CORPS OF THE U. S. NAVY, FOR THE WEEK ENDING APRIL 26, 1890.

SCOFIELD, W. K.—Commissioned a Medical Director from February 8, 1890.

MC MURTRIE, DANIEL.—Commissioned a Medical Inspector from February 8, 1890.

BOGERT, E. S.—Commissioned an Assistant Surgeon from April 16, 1890.

SPRATLING, D. W.—Commissioned an Assistant Surgeon from April 16, 1890.

MARTIN, H. M., *Surgeon*.—Reported his return home, and granted sick-leave.

WOOLVERTON, T., *Medical Inspector*.—Detached from the Navy Yard, Washington, D. C., and wait orders.

BEYER, H. G., *Passed Assistant Surgeon*.—Ordered to delay reporting on board the "Yantic" until further instructed.

OFFICIAL LIST OF CHANGES OF STATIONS AND DUTIES OF MEDICAL OFFICERS OF THE U. S. MARINE-HOSPITAL SERVICE, FROM APRIL 7 TO APRIL 19, 1890.

FESSENDEN, C. S. D., *Surgeon*.—To proceed to Marion, Ky., on special duty, April 16, 1890.

BAILHACHE, P. H., *Surgeon*.—Detailed as Chairman of the Board for Physical Examination of Officers of Revenue Marine Service, April 12, 1890. To proceed to Portland, Oregon, Tacoma, Seattle, and Port Townsend, Wash., as Inspector, April 16, 1890.

HUTTON, W. H. H., *Surgeon*.—Detailed as Chairman of the Board for Physical Examination of Officers of Revenue Marine Service, April 10, 1890.

LONG, W. H., *Surgeon*.—To proceed to Marion, Ky., on special duty, relieving Surgeon Fessenden, April 18, 1890.

KALLOCH, P. C., *Passed Assistant Surgeon*.—Detailed as Recorder of the Board for Physical Examination of Officers of Revenue Marine Service, April 12, 1890.

MAGRUDER, G. M., *Assistant Surgeon*.—Detailed as Recorder of the Board for Physical Examination of Officers of Revenue Marine Service, April 10, 1890.

GUIERAS, G. M., *Assistant Surgeon*.—To report to the Superintendent of Immigration, New York, for special duty, April 12, 1890.